State Advisory Committee on Mental Health Services
February 3, 2011 – 9:00 a.m. to 4:00 p.m.
Country Inn & Suites – 5353 No. 27th St. Lincoln, NE

Mental Health Committee Members Present (19):
Adria Bace, Beth Baxter, Roxie Cillessen, Pat Compton, Cheryl Crouse, Sharon Dalrymple, Scot Ford, Dwain Fowler, Melanie Lantis, Kathy Lewis, Dave Lund, Vicki Maca, Kasey Moyer, Colleen Manthei, Ed Matney, Mark Schultz, Pat Talbott, Diana Waggoner, Cameron White

Mental Health Committee Members Absent (4):
Bev Ferguson, Jette Hogenmiller, Jerry McCallum, Joel Schneider

DHHS Staff Present:
Scot Adams, Alexandra Castillo, Maya Chilese, Carol Coussons de Reyes, Sheri Dawson, Jim Harvey, Nancy Heller, Ashley Nielson, Blaine Shaffer, Marla Augustine, Paula Hartig, Judy Martin, Shirley Deethardt

Guests Present:
Alan Green, Ingrid Gansebom, Linda Jensen, Patti Jurjevich,

I. Call to Order
Vice Chairperson, Pat Talbott called the meeting to order at 9:00 a.m. Committee members introduced them self. Roll call was conducted and determined a quorum was met.

II. Approval of Minutes and Agenda
√ Motion was made by Ed Matney and seconded by Sharon Dalrymple to approve the November 4, 2010 Minutes and approve the February 3, 2011 Agenda. Abstained from voting were: Pat Talbott and Kasey Moyer. Voice vote was in favor and motion carried.

III. DIVISION REPORTS

BH Consumer Survey – Paula Hartig **Attachment A**
Ms. Hartig stated the survey instrument was the same as was used last year, and is used by many states. There was a 75% response rate, which is a good percentage of return. Confidence level of responses is within +/- 2.8% Margin of Error. A summary report is on the DBH-Community Based Services website.

Committee Comments:
- Are there numbers of consumers who do not participate because they have not received treatment? Estimates are provided in the MH block grant.
- BH has a Network of Care web site with a map of Nebraska and options to guide you to services.
- The top 5 scales (Access; Quality and Appropriateness of Services; Outcomes; Participation in Treatment Planning; and General Satisfaction have a high response rate.
- Some survey questions are based on how long in service.
- Some survey questions are based on age and type of service received.
- Some questions regarding general health are completed by self report.
- Surveys are conducted by telephone—both land line and cell phones.
- What is done with the data? How do we compare it to other states?
- Jim Harvey reported consumer survey outcomes are posted on the BH website.
- How are surveys used with Quality Improvement? Information is included in the weekly data call.
- Is something being done to have youth self report rather than their parents reporting? The Division is looking into having youth self report for the 2012 survey.
- What is the percentage of youth in Nebraska seeking services?
- Suggested, partnering with people/organizations that have a direct contact with youth to get a higher response to consumer survey.

- Confidentiality concerns may arise for children with MH issues. Parents/children may not want it known.
- 5% of recipients of services are responding. The random sample could be increased but funds are an issue.
- Are the samples different for different geographic areas and different age groups?
- Suggestion for Division to follow-up with people who did not respond.
- For the May 3, 2011 joint meeting, discuss how to get information from other states.

√ Motion was made by Sharon Dalrymple and seconded by Kasey Moyer to have the BH Division to explore the feasibility of administering the youth questions directly to the youth to get their responses versus their parents' responses to the consumer survey questions. Voice vote was in favor and motion carried.

Tobacco Free Nebraska — Judy Martin & Shirley Deethardt **Attachment B**

Ms. Martin reported tobacco sales/use costs everyone in the form of taxes, work loss and health care. The approach needs to be broader for anti-smoking campaign to encourage campuses to be smoke free, not just a smoke free building. The CDC has solid data that shows a correlation between the increase of tobacco products prices to a decrease in the use of tobacco. Ms. Martin invited the Mental Health Advisory Committee members to partner with Tobacco Free Nebraska to help with awareness and prevention.

Shirley Deethardt explained tobacco addiction is stronger than heroin or alcohol and the most difficult to quit. Sometimes it takes up to 15 or more attempts in quitting. 5 barriers to quitting were reviewed. Tobacco Free Nebraska has a help line and a quit line. One person is matched with one counselor. Counselors will call the person to check on them and help them as needed. Shirley handed out several brochures to the committee 1) cessation 2) young people quit 3) quit line cares 4) information on quitting and posters.

Committee Comments:

- Is the chewing tobacco as habit forming? Yes, it can be.
- Committee members expressed concerns that the TFN brochure language is offensive to individuals with Mental Health diagnosis.
- BH – Quality Improvement is working with OCA on a Peer to Peer Quit Smoking program.
- Nebraska prisons went smoke free 8 years ago.
- The cost to tax payers: 1 cent of State cigarette tax = $650,000 in revenue per year.

√ Motion was made by Dave Lund and seconded by Mark Schultz to partner with Tobacco Free Nebraska to plan and implement the DBH Strategic Plan to decrease tobacco use by promoting cessation, education, and the quit line, to explore resources available through Medicaid, and to promote and increase participation in Peer to Peer training. In addition, future publications and discussions will be consumer driven using person first language so materials are sensitive to Mental Health consumers and/or family of consumers so as not to reinforce negative messages. Voice vote, Cheryl Crouse was opposed, Sharon Dalrymple abstained. The majority of votes were in favor. Motion carried.

KEYA HOUSE Update – Alan Green, Mental Health Association **Attachment C**

MHA completed surveys and based on the results, the Keya House was developed. The house is modeled after the Rose House in New York, and has been operational since December, 2010. The goal of the house is to keep individuals from relying on crisis services. A total of 83 individuals have utilized Keya House this past year. Keya House is a crisis aversion service for adults with self-awareness of their mental illness and are developing their personal wellness program/package. The House is a consumer-run house, all programs are recovery-based, not clinical. Each guest indentifies the reason for their stay at Keya House. The unit of service is one guest/day, the average length of stay is 4.8 days, the unit cost is $182.00 per day, and is funded by Region 5 Behavioral Health Systems. The guest cannot be homeless – they must have a place to go to after the five days. In the past individuals used the hospital as a safe haven, therefore Keya House has proven to be much cost effective and an efficient use of funding dollars.

Keya House has developed collaboration with Lincoln Police Department, Community Mental Health Center, Cornhusker Place, Friendship Home, and Mental Health Association. Detox performs wellness checks, and has taken persons to Keya House.

Developing other houses like Keya House are a very real possibility because of the success of the model, as well as needing efficient and effective services in light of the economy and future changes to block grant funding. MHA is looking at CARF accreditation for Keya house.

Region 6 Presentation- Patti Jurjevich **Attachment D**

Ms. Jurjevich presented a handout on Region 6 activities. Challenges include access to services, and special populations such as elders, and nursing home consumers. Region 6 is discussing establishing peer-run services and plans to complete a Request for Proposal in the next 6 months.

Committee Comments:

- Region 6 has a good variety of services.
- Very good presentation followed the handout.
- What is the availability of SA/MA services individuals without insurance? Is the waiting list long?

DIRECTOR's Report - Scot Adams

Director Scot Adams briefly reviewed the Strategic Plan draft. It can be viewed at the following website: http://www.dhhs.ne.gov/Behavioral_Health/BHSP. Diana Waggoner and Kasey Moyer were the volunteers from this committee involved in the strategic planning workgroup. The Strategic Plan will shape the organization of the Division of Behavioral Health, as well as the focus of the Advisory Committee and Regional services.

Committee Questions to the Division/Director:

- The MH Grant was well thought out and composed
- DBH and the Department of Correctional Services continue good collaboration and relationship
- The child system is unsettled, there are needs that need to be addressed.
- SAMHSA integration and what does it mean for the Advisory Committees
- Partner with peers
- Elder care is not available
- There is a shortage of Psychiatrists
- Concerned with the loss of Boys/Girls home.
- Is there a need to combine the MH/SA Advisory Committees more than once a year.
- Do we need separate Advisory Committees for Youth and Adults?
- Concern with how we are doing with preparing young criminal offenders to go out into the world, and what is their quality of life?
- Based on cost of medications it is difficult for MH consumers to continue to work.
- Concern with some Assisted Living facilities failure to take care of individuals' basic needs—these facilities are not funded by BH and concerns should be directed to the Division of Public Health
- A hearing is being held on a Legislative Bill to cover new medications under Medicare or Medicaid
- Consider DBH shifting funds to facilities like Keya House as part of the continuum of care
- What can we do that hasn't been thought of yet?

IDTA - Vicki Maca

Nebraska is receiving Technical Assistance from the National Center on Substance Abuse and Child Welfare. The purpose is to bring together the entities that are responsible for serving parents with addictions and who have children in the welfare system to discuss ways to improve the system so more parents receive necessary treatment and fewer parents lose their parental rights. The agencies involved are: DBH, Medicaid and Long-Term Care, Children and Family Services, Public Health, Juvenile Probation, and the UNL Center for Children, Families, and the Law. Discussion continues on who will pay for the services. The five focus areas are: Data, Training and Best Practices, Funding, Screening and Assessment, and Drug-Addicted Newborns. Partnerships are a plus in this endeavor. Currently Children

and Family Services do not conduct drug and alcohol screening while investigating a child abuse/neglect case.
The committee asked what is the number of families involved? Currently there are 5,000 to 6,000 State Wards, and 80%-85% of those families have been identified with addictions.

PATH Report - Nancy Heller **Attachment E**
PATH is Projects for Assistance in Transition from Homelessness.
Nancy presented a handout of PATH information and activities. Outreach provides items such as, water resistant socks, granola bars and sleeping bags. The PATH Grant is $300,000 per year. DBH contracts with four providers – Cirrus House in Scottsbluff (Region 1) receives approximately $11,000, Goodwill in Grand Island (Region 3) receives approximately $11,000, CenterPointe in Lincoln (Region 5) receives approximately $65,000, and Community Alliance in Omaha (Region 6) receives approximately $230,000.

MH Block Grant Federal Site Visit - Jim Harvey
The MH Block Grant Application is on the DBH website. A group of committee members will be needed to comment on how DBH works with committee.

The block grant format will likely be changed next fiscal year. It is likely that MH and SA will be on one application, and the budget time frame will change to a two-year cycle.

Special Initiative Employment Development – Jim Harvey **Attachment F**
Nebraska submitted an application along with 28 other states. Only 9 of the states are funded and Nebraska was not funded, likely due to having one of the lowest unemployment rates. There will other grant application opportunities in the future. A handout was provided by Voc Rehab.

By-Laws - Jim Harvey **Attachment G**
A set of duties of this committee are spelled out in the Committee By-Laws. An amendment to the bylaws in Section I, page 3 involves adding to the Secretary duties. A question was raised on the meaning of Article II, Section 2, Number (3) "to monitor, review and evaluate not less than once each year, the allocation and adequacy of MH services within the State." More information is needed so this will become an Agenda Item for next meeting.

The committee discussed the following changes: (1) Article VI, Section 3, last sentence "...the Division shall mail (change to deliver notification) of meeting agenda..."; (2) Article VI, Section 5, add a space between sections and 81-1174; (3) Article VII, capitalize all mention of "Committee" for consistency; (4) Article VIII, last sentence of first paragraph, "proposed changes has been mailed (change to delivered) to members..." Dave Lund made a motion, and Scot Ford seconded the motion to accept the changes as discussed by the Committee. A Roll Call vote was taken and the motion carried to approve the By-Law changes.

IV. <u>Public Comment</u>
Alan Green – MHA: Tobacco use is a choice people make; LB275 related to smoking on the grounds of hospital facilities—it will criminalize anyone walking away from a regional hospital facility; a common belief of people with Mental Illness that it equals Violent Paranoia; during an EPC the behavior of an individual is knowingly dangerous to self and others due to their mental illness, can be a quite a broad statement; On February 27, 2011, MHA is sponsoring a Legislative breakfast to promote MH programs and education, and to encourage the Legislature to leave the DBH budget alone.

Linda Jensen - LB466 hearing on Friday, February 4, 2011 on exclusion to drug list related to antipsychotic medications and access to necessary medications.

Agenda items for next meeting

1. Sheri Dawson present on NOMS
2. Form an Ad Hoc Committee to discuss the By-Laws and meaning of "Article II, Section 2, Number (3) "to monitor, review and evaluate not less than once each year, the allocation and adequacy of MH services within the State." Ad Hoc Committee will make a recommendation to the full Committee.
3. Integrate primary care with Mental Health and Substance Abuse
4. Strategic Plan
5. DBH Director

V. Plus/Delta:

--Pat did a great job as Chair
--The column was not blocking committee members.
--Good conversation; good atmosphere; laughter
--Room temperature on the cold side
--The meeting was productive; notice that the agenda is changing directions
--Appreciate good attendance

VI. Adjournment & Next Meeting

Meeting adjourned at 4:00 pm

The next meeting date is: Tuesday, May 3, 2011 at Country Inn and Suites (Joint Advisory Committees)

Prepared by: Alexandra Castillo, Staff Assistant

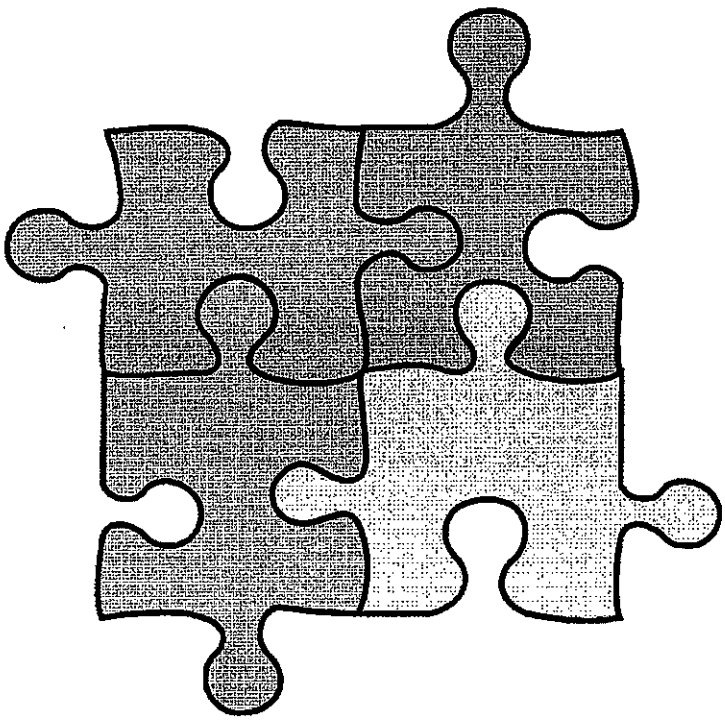
Approved by X _____ Date 4/18/2011
Federal Resource Manager
Division of Behavioral Health

4/8/11 nh

Attachment A

Nebraska 2010 Behavioral Health Consumer Survey

Summary of Results



Nebraska Department of Health and Human Services
Division of Behavioral Health
January 2011

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Nebraska 2010 Behavioral Health Consumer Surveys
Summary of Results

Introduction

During the spring and summer of 2010, the Department of Health and Humans Services' (DHHS) Division of Behavioral Health conducted the annual Behavioral Health Consumer Surveys. The purpose of the surveys was to solicit input from persons receiving mental health and/or substance abuse services from the publicly-funded, community-based behavioral health system in Nebraska on the quality and impact of services received. The survey instruments used were:

a) the ***28-Item Mental Health Statistics Improvement Program (MHSIP) Consumer Satisfaction Survey*** (augmented with 11 questions on improved functioning and social connectedness and one question on quality of life),
b) the ***MHSIP Youth Services Survey (YSS),*** and
c) the ***MHSIP Youth Services Survey for Families (YSS-F).***

[Note: These survey instruments have been designated by the federal Center for Mental Health Services to meet the Federal Community Mental Health Services Block Grant, Uniform Reporting System requirements for Table 9: Social Connectedness & Improved Functioning and Table 11: Summary Profile of Client Evaluation of Care.]

Methodology and Sample

The Division of Behavioral Health contracted with the University of Nebraska Medical Center - College of Public Health (UNMC) to conduct the 2010 Behavioral Health Consumer Surveys.[1]

The sample for the surveys included persons receiving mental health and/or substance abuse services from the Nebraska community-based Behavioral Health System. Magellan Behavioral Health supplied a list of names, addresses and phone numbers of current mental health/ substance abuse consumers to UNMC. UNMC conducted the telephone interviews and entered responses from the phone and mail surveys into the survey database. Data from the surveys were compiled and analyzed by the Research and Performance Measurement unit in DHHS – Financial Services - Operations.

A letter to the consumer was prepared by the Division of Behavioral Health which introduced the survey and explained how the UNMC would be contacting them by phone to solicit their participation in the survey. The phone number of the consumer was included in the introductory letter. The letter was sent to the consumers in the sample, providing them with three options: 1) to be interviewed over the telephone by a professional interviewer; 2) to be sent a mail survey; or 3) to decline participation in the survey. The consumer was given a toll-free number to indicate their choice to participate, by phone or mail, or to decline participation.

[1] Questions regarding the 2010 Behavioral Health Consumer Surveys should be directed to Jim Harvey, Department of Health and Human Services, Division of Behavioral Health at: 402-471-7824 or email: jim.harvey@nebraska.gov.

If the consumer did not respond to the letter, they were contacted by phone, when they were again given an opportunity to decline participation.

Interviewers for the Behavioral Risk Factor Surveillance System (BRFSS) conducted the telephone interviews. Consumers electing to receive a mail survey were sent a survey. If they did not respond within the designated time, they were sent a follow-up survey.

Of the 5,790 persons in the adult sample, nearly 800 declined to participate. An incorrect or non-working telephone number, or an incorrect address, had been provided for some consumers, so they could not be contacted. In all, 1,124 adult consumer surveys were completed, a 3% increase over 2009. (The confidence interval for the Adult survey was +/- 2.86% at the 95% confidence level.) Of the 701 youth (or parents) in the sample, 232 completed the survey. (The confidence interval for the Youth survey was +/- 6.21% at the 95% confidence level.)

Again in 2010 the Department incorporated questions from the Behavioral Health Risk Factor Surveillance System (BRFSS)[2], a national survey of adults in all 50 states, into the consumer survey. These questions were added to gauge the physical health status of behavioral health consumers.

Survey data were analyzed by race, gender, age, type of services received, and service location (metro vs non-metro). In addition, the responses to multiple survey questions were combined into the following seven scales or "domains" (see Appendix A for the questions included in each scale, an explanation of the calculation of scale scores, and information on scale reliability):

- Access
- Quality and Appropriateness of Services
- Outcomes
- Participation in Treatment Planning
- General Satisfaction
- Functioning
- Social Connectedness

Survey Results

Adult Survey – Summary of Results

Over half (55%) of the adult respondents in 2010 were female. The respondents ranged in age from 19 to 83, with an average age of 41 years. Most (85.8%) were White, 4.0% were Black and 2.9% were American Indian. About seven percent were Hispanic or Latino.

[2]The Behavioral Risk Factor Surveillance System (BRFSS) is an ongoing telephone health survey of adults ages 18 and over which has collected information on health conditions, health risk behaviors, preventive health practices and health care access in the U.S. since 1984. The BRFSS is used in all 50 states, the District of Columbia, Puerto Rico, Guam and the Virgin Islands. Over 350,000 persons are interviewed by the BRFSS each year, making it the largest telephone survey in the world.

Generally speaking, consumers appeared to be satisfied with the services they received from community mental health and/or substance abuse programs in Nebraska. In the area of **General Satisfaction,** most adult respondents (84.8%) were satisfied with services (Table 1). About 6.7% percent were dissatisfied with services, and 8.6% were neutral. More than three-fourths (80.3%) were satisfied with their level of involvement in treatment planning. Three-fourths (75.6%) responded positively to questions on the **Outcomes** scale. Most (88.7%) responded positively to the questions related to the **Quality and Appropriateness** of services, and 82.4% thought that the services were **Accessible.** Most consumers felt that the services they received improved their level of **Functioning** (81.6%) and **Social Connectedness** (78.5%).

While males tended to respond more positively than females on several of the scales (**Outcomes, Functioning** and **Social Connectedness**), none of the differences were statistically significant. Both males and females responded significantly more positively to questions in the **Quality/Appropriateness** domain than to questions in the **Outcomes, Participation in Treatment Planning,** and **Social Connectedness** domains.

Persons aged 65 and older tended to respond more positively to the survey than the other age groups. Persons aged 65 and older responded significantly more positively than persons ages 25-44 on the **General Satisfaction** scale, and significantly more positively than all other age groups (19-24, 25-44, 45-64) on the **Participation in Treatment Planning** scale.

There were no significant differences between responses for White, non Hispanic adults versus non-White or Hispanic adults. Consumers who were White, Non-Hispanic responded significantly more positively to the questions regarding **Appropriateness/Quality** of services than they did to questions regarding **Outcomes, Social Connectedness** and **Functioning.** There were no significant differences among the scales for persons who were non-White or Hispanic.

TABLE 1: Agreement Rates by Consumer Characteristics/Services Received/Provider Location

	Access	Quality/ Approp	Outcomes	Participation In Treatment Planning	Gen Satis	Func	Soc Conn
All Respondents	**82.4%**	**88.7%**	**75.6%**	**80.3%**	**84.8%**	**81.6%**	**78.5%**
Gender							
Male	82.2%	88.6%	77.6%	80.3%	84.0%	82.7%	80.2%
Female	82.5%	88.8%	73.9%	80.3%	85.4%	80.7%	77.0%
Age							
19-24 years	79.8%	91.4%	69.6%	78.9%	82.8%	85.3%	84.8%
25-44 years	82.8%	90.2%	78.6%	83.2%	84.5%	85.4%	79.9%
45-64 years	83.0%	87.1%	74.3%	76.6%	86.1%	77.6%	76.4%
65+ years	90.0%	92.9%	86.2%	100.0%	93.5%	86.7%	86.7%
Race/Ethnicity:							
White, non Hispanic	82.4%	89.2%	75.0%	80.5%	85.1%	81.5%	78.0%
Non-White or Hispanic	83.7%	87.1%	79.4%	80.5%	83.2%	82.6%	81.8%

Mental Health versus Substance Abuse Services

Respondents were asked the type of services they had received in the last 12 months. Persons receiving **both** mental health and substance abuse services in the last 12 months tended to respond more positively on all seven scales than persons receiving mental health services only (Table 2).

In addition, persons receiving substance abuse services only responded significantly more positively than persons receiving mental health services only on two scales: **Social Connectedness** and **Functioning**. There were also some significant differences for individual survey questions. For example, persons receiving substance abuse services responded significantly more positively than persons receiving mental health services to the following questions:

As a result of the services received:

26. I do better in school and/or work.
28. My symptoms are not bothering me as much.
31. I am better able to handle things when they go wrong.

34. I have people with whom I can do enjoyable things.
35. I feel I belong in my community.

TABLE 2: Agreement Rates by Type of Services Received in Last 12 Months

	Access	Quality/ Approp	Outcomes	Participation in Treatment Planning	Gen Sats	Func	Soc Conn
Services Received Last 12 Months:							
MH Only	83.4%	86.4%	72.3%	78.6%	85.8%	76.2%	72.7%
SA Only	82.6%	93.0%	84.2%	82.1%	85.5%	88.0%	89.2%
Both MH and SA	87.1%	94.4%	82.6%	85.5%	89.4%	87.9%	84.8%
No Services	79.1%	88.7%	74.0%	79.3%	82.1%	83.0%	78.7%

Behavioral Health Region/Metro – Non-Metro Service Providers

Although the response rates for some of the Behavioral Health Regions were too low to report on separately, there did not appear to be any significant differences among the six Regions on any of the seven scales; however, there appeared to be some significant differences *among the seven scales within* some Regions. For example, in Region 2, consumers responded significantly more positively to questions about the **Appropriateness/Quality** of services than to questions about **Outcomes** or **Social Connectedness**. Consumers in Regions 4, 5 and 6 also responded more positively to questions about **Appropriateness/Quality** of services than to questions about **Outcomes**. Consumers in Region 5 responded significantly more positively to questions about **Functioning** than to questions about **Social Connectedness**.

Responses for metro providers (those located in the Omaha/Lincoln metro areas) were compared to responses for non-metro providers (those outside the Omaha/Lincoln metro areas). Respondents receiving services from non-metro providers responded more positively than respondents receiving services from metro providers to questions on six of the seven scales, although none of the differences were statistically significant (Table 3).

TABLE 3: Agreement Rates by Location of Service Provider

	Access	Quality/ Approp	Outcomes	Participation in Treatment Planning	Gen Satis	Func	Soc Conn
Provider Location:							
Metro	79.9%	87.8%	76.2%	79.2%	84.4%	80.5%	78.0%
Non-Metro	84.9%	89.7%	75.0%	81.5%	85.1%	82.8%	78.9%

Length of Time Receiving Services

The length of time a person received services had an effect on their overall satisfaction with services. Persons who had received services for a year or more responded significantly more positively to the questions about **General Satisfaction**; however, they responded significantly **less** positively to questions about **Functioning.**

Overall, in 2010, consumers responded significantly ***more*** positively than in 2009 to the following survey questions:

I am happy with the friendships I have.
I feel I belong in my community.
In a crisis, I would have the support I need from family or friends.

Scale Summaries – 2006-2010

Table 4 compares the responses from the 2006 to 2010 adult surveys for each of the seven MHSIP domains (scales). The responses were more positive for six of the seven domains from the 2009 survey to the 2010 survey. In 2010, the responses to five of the domains were more positive than for any of the previous five years: **Access, Quality/Appropriateness, Outcomes, Participation in Treatment Planning,** and **Functioning.**

TABLE 4: Agreement Rate by Scale – 2006-2010

	2006	2007	2008	2009	2010
Access	77.1%	81.4%	76.3%	82.1%	82.4%
Quality/Appropriateness	82.2%	84.9%	81.9%	87.8%	88.7%
Outcomes	68.4%	72.9%	72.0%	71.5%	75.6%
General Satisfaction	78.6%	81.1%	75.9%	86.3%	84.8%
Participation in Treatment Planning	73.0%	78.1%	73.1%	79.8%	80.3%
Functioning	71.4%	77.4%	80.4%	73.7%	81.6%
Social Connectedness	87.7%	74.5%	76.3%	75.2%	78.5%

A summary of the responses to the 28-item MHSIP survey for adults for 2010, plus the eight questions related to improved Functioning and Social Connectedness, can be found in Appendix B.

Physical Health Status of Adult Behavioral Health Consumers

To measure the presence of chronic physical health conditions among behavioral health clients, six questions from the Behavioral Health Risk Factor Surveillance System (BRFSS) were included on the consumer survey in 2010:

Has a doctor, nurse, or other health professional ever told you that:

a) you had a heart attack (also called a myocardial infarction)?
b) you had angina or coronary heart disease?
c) you had a stroke?
d) your blood cholesterol was high?
e) you had high blood pressure?
f) you had diabetes?

The most common chronic health conditions among behavioral health consumers were high blood cholesterol (31.9%) and high blood pressure (31.7%). One in nine (11.6%) had Diabetes. Fewer than one in 25 behavioral health consumers reported having been told by a health care professional that they had angina or coronary heart disease (3.6%), a heart attack (3.2%), or a stroke (3.0%).

When asked whether they smoked cigarettes, half (50.2%) indicated that they did not smoke, 41.3% reported that they smoked every day, and 8.2% reported that they smoked "some days".

When asked to assess their general health, 10.1% rated their general health as "Excellent"; 23.0% rated their general health as "Very Good"; 39.1% rated their general health as "Good"; 19.9% rated their general health as "Fair"; and 7.3% rated their general health as "Poor".

Adult consumers were then asked two questions about the number of days in the previous 30 days that their physical or mental health was not good:

1) *Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?*
2) *Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?*

Respondents reported an average of 6.3 days in the previous 30 days that their physical health was not good, down from 8.1 days in 2009. Consumers reported an average of 8.1 days in the previous 30 days that their mental health was not good, down from an average of 9.5 days in 2009.

Consumers were then asked how many days during the past 30 days that poor physical or mental health kept them from doing their usual activities. Over one-third (39.1%) reported that

there were no days in the past 30 days when poor physical or mental health kept them from doing their usual activities. The average number of days when poor physical or mental health kept them from doing their usual activities was 7.3 days.

Differences were noted between persons admitted primarily for a mental health problem versus those admitted primarily for a substance abuse problem. Table 5 shows the differences between the two groups for selected questions.

Persons receiving mental health services were more likely than persons receiving substance abuse services to have high cholesterol and diabetes. Persons receiving mental health services reported more days when their physical and mental health were not good, and more days when poor physical or mental health kept them from doing their usually activities. Persons receiving mental health services were more likely than persons receiving substance abuse services to be obese (41.3% vs 28.7%, respectively), and to be underweight, while persons receiving substance abuse services were more likely to be of normal weight. Persons receiving substance abuse services were more likely to be smokers and to report their general health status as Good, Very Good, or Excellent.

Responses to the health questions on the consumer survey were compared to responses to the BRFSS for the general adult population in Nebraska for the latest year available. Those comparisons are shown in Table 5. Behavioral health consumers were slightly more likely than the general adult population to report having high blood pressure. Mental health consumers were about twice as likely as the general population to report having Diabetes. Behavioral health consumers, especially those receiving substance abuse services, were much more likely than the general population to report smoking cigarettes on a daily basis. The general population rated their health status significantly better than the behavioral health consumers. Behavioral health consumers experienced significantly more days in the past 30 days when their physical and/or mental health were not good, as compared to the general population.

TABLE 5: Differences on BRFSS Questions Between Persons Receiving Mental Health versus Substance Abuse Services and the General Adult Population in Nebraska

	Primary Reason for Admission		Nebraska General Population
	MH	SA	
Physical Health Conditions:			
Heart Attack or Myocardial Infarction	3.3%	4.9%	3.9%
Angina or Coronary Heart Disease	4.2%	2.6%	4.0%
Stroke	3.3%	2.6%	2.4%
High Blood Cholesterol	36.6%	26.0%	36.6%
High Blood Pressure	35.8%	31.3%	26.5%
Diabetes	15.3%	6.8%	7.4%
Cigarette Smoking:			
Every Day	41.6%	58.6%	14.0%
Some Days	7.6%	8.6%	5.2%
Does Not Smoke	50.8%	32.7%	80.8%
General Health Status:			
Excellent	8.5%	12.8%	20.5%
Very Good	21.9%	25.9%	36.6%
Good	38.7%	42.5%	30.9%
Fair	23.1%	13.5%	9.2%
Poor	7.8%	5.3%	2.8%
In the Past 30 Days:			
Average Days Physical Health Not Good	7.0	4.3	2.8
Average Days Mental Health Not Good	9.3	6.5	2.5
Average Days Poor Health Prevented Usual Activities	8.1	6.6	3.3
Average Days of Binge Drinking	0.8	1.6	NA
Body Mass Index Category:			
Obese	41.3%	28.7%	27.3%
Overweight	32.7%	33.3%	37.0%
Normal Weight	25.1%	36.4%	35.7%
Underweight	0.9%	1.6%	

Youth Survey

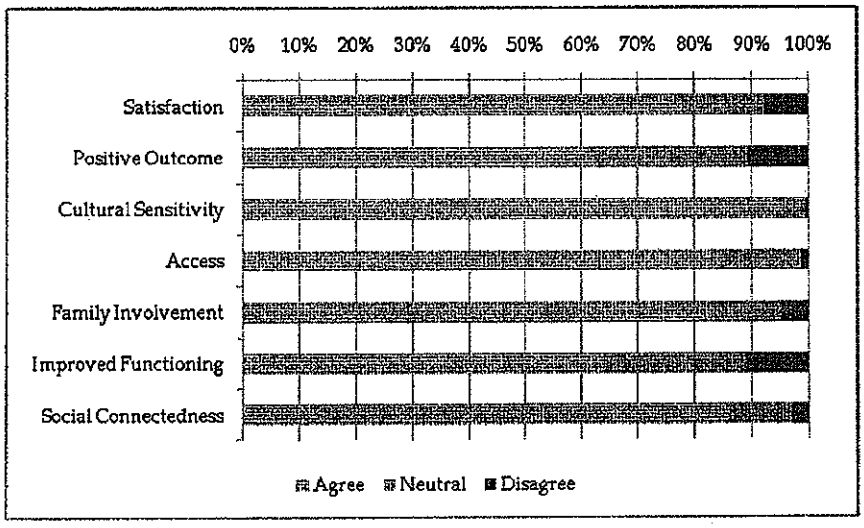
A total of 232 MHSIP youth surveys were completed in 2010, up from 131 in 2009. In most cases, a parent or guardian responded on behalf of the child receiving services. More surveys were completed for boys (62.5%) than for girls (37.5%). The youth's ages ranged from 4 years to 19 years, with an average age of 14.1 years. Most of the respondents were White, non Hispanic (72%); 28% were non-White or Hispanic. Half (51%) have Medicaid coverage. Over half (56%) had not received services in the past 12 months; 30% had received community mental health services in the past 12 months, and 13% had received community alcohol or drug abuse services in the past 12 months.

For the Youth survey, responses for multiple questions were combined into the following five scales or "domains" (see Appendix A for the questions included in each): Satisfaction, Positive Outcome, Cultural Sensitivity, Access and Family Involvement.

Youth Survey – Summary of Results[3]

Most of the respondents (77.9%) to the Youth Survey indicated that they were satisfied with the services their child received (Figure 1). Eight percent (7.8%) were dissatisfied with the services their child received, and 14.3% were neutral. The most positive responses were in the **Cultural Sensitivity** domain – 94.6% responded positively. The responses to the 2010 survey were more positive than responses to the 2009 survey on all scales except the **Social Connectedness** scale.

Figure 1
Statewide Summary – MHSIP Scales – Youth



A summary of the responses to the MHSIP survey for youth for 2010 can be found in Table 3, Appendix B.

Physical Health Status of Youth Behavioral Health Consumers

The youth/parents were asked some of the same health questions from the BRFSS as the adults. When asked to rate the youth's general health, about one-third (32.3%) rated their general health as Excellent, 30.5% rated their general health as Very Good, and 25.9% rated their general health as Good. One in nine (9.5%) rated their general health as either Fair or Poor.

The youth reported an average of 1.2 days in the past 30 days that their physical health was not good, 7.5 days when their mental health was not good, and 2.4 days when poor physical or mental health kept them from doing their usual activities. When asked whether the child, in the past 30 days, participated in any physical activity or exercises such as running, sports, swimming, PE or walking for exercise, 84.1% said "yes", 12.1% said "no", and 3.4% weren't sure.

[3] Because of the small sample size, and the large confidence interval (+/-6.2%), caution should be exercised in interpreting the results of the Youth Survey.

The youth's weight, height, gender, and age were used to determine their weight status. Three percent were considered underweight, over half (56.5%) were considered to have healthy weight, 15.5% were classified as overweight, and 25.0% were classified as obese.

Quality of Life Question

One question was added to the 2010 surveys to gauge the impact of services on the quality of life for consumers: *The services you received at [Provider Name] has improved your quality of life.* Most adults (82.2%) responded positively to this question. Nearly three-fourths (72.2%) of the youth responded positively to this question.

Table 6 provides a summary of the responses to this question for the adult and youth surveys. Persons receiving both mental health and substance abuse services responded more positively to this question than persons receiving only mental health or only substance abuse services. Persons receiving services for a year or more also responded more positively to this question than persons receiving services for less than one year. For the adults, the responses were more positive in the older age groups than in the younger age groups. For youth, the responses were the most positive for children under six years of age.

TABLE 6: Summary of Responses to the Quality of Life Question

	Adult Survey	Youth Survey
All Respondents	**82.2%**	**72.2%**
Type of Services Received:		
Mental Health Services Only	84.4%	66.1%
Substance Abuse Services Only	83.0%	80.0%
Both MH and SA Services	86.2%	100.0%
No Services Last 12 Months	78.0%	70.1%
Length of Time Receiving Services:		
Less Than One Year	77.8%	67.8%
One Year or More	85.7%	78.9%
Gender:		
Male	82.3%	74.3%
Female	82.2%	68.6%
Race/Hispanic Origin:		
White, non-Hispanic	82.3%	71.9%
Non-White, or Hispanic	81.7%	73.0%
Age:		
< 6 Years	NA	83.3%
6-9 Years	NA	73.9%
10-14 Years	NA	69.0%
15-18 Years	NA	74.6%
19-24 Years	77.4%	NA
25-44 Years	81.6%	NA
45-64 Years	83.8%	NA
65+ Years	93.3%	NA

Survey Sample and Response Rates

Table 7 shows a summary of sample size and response rates for the last six years. The response rate for the Adult survey increased from 29% in 2009 to 37% in 2010. For the Youth survey, the response rate increased from 32% in 2009 to 57% in 2010.

TABLE 7: Survey Sample Size and Response Rates – 2005-2010

Adult Survey	2005	2006	2007	2008	2009	2010
a. How many Surveys were Attempted (sent out or calls initiated)?	4,821	3,592	5,198	5,980	8,407	5,790
b. How many survey Contacts were made? (surveys to valid phone numbers or addresses)	1,567	1,471	2,145	3,238	3,748	3,001
c. How many surveys were completed? (survey forms returned or calls completed)	749	795	1,173	1,019	1,090	1,124
d. What was your response rate? (number of Completed surveys divided by number of Contacts)	48%	54%	55%	31%	29%	37%
Youth Survey	2005	2006	2007	2008	2009	2010
a. How many Surveys were Attempted (sent out or calls initiated)?	768	1,567	1,037	784	928	701
b. How many survey Contacts were made? (surveys to valid phone numbers or addresses)	497	880	537	306	423	410
c. How many surveys were completed? (survey forms returned or calls completed)	235	465	254	128	135	232
d. What was your response rate? (number of Completed surveys divided by number of Contacts)	47%	53%	47%	42%	32%	57%

Table 8 shows a summary of the data reported by the Division of Behavioral Health to the Center for Mental Health Services for the Federal Community Mental Health Services Block Grant, Uniform Reporting System Table 11: Summary Profile of Client Evaluation of Care for 2008 through 2010. For the adult survey the responses in 2010 were more positive than the responses in 2009 for four of the five domains: **Access, Quality and Appropriateness, Outcomes,** and **Participation in Treatment Planning.** The responses for the fifth domain – **General Satisfaction** – were slightly lower in 2010 than in 2009. For the Youth Survey, improvement from 2009 to 2010 was seen in all five domains reported: **General Satisfaction, Outcomes, Participation in Treatment Planning** and **Cultural Sensitivity.**

TABLE 8: Summary Profile of Client Evaluation of Care/Nebraska Consumer Survey Results (URS Table 11)

Report Year (Year Survey was Conducted)	2008			2009			2010		
Adult Consumer Survey Results	Number of Positive Responses	Responses	Percent	Number of Positive Responses	Responses	Percent	Number of Positive Responses	Responses	Percent
1. Percent Reporting Positively About **Access.**	743	974	76.3%	870	1,060	82.1%	918	1,114	82.4%
2.Percent Reporting Positively About **Quality and Appropriateness** for Adults.	793	968	81.9%	918	1,046	87.8%	978	1,102	88.7%
3. Percent Reporting Positively About **Outcomes.**	688	955	72.0%	739	1,033	71.5%	822	1,087	75.6%
4. Percent of Adults Reporting on **Participation in Treatment Planning.**	638	873	73.1%	788	988	79.8%	849	1,057	80.3%
5. Percent of Adults Reporting Positively about **General Satisfaction** with Services.	767	1,010	75.9%	928	1,075	86.3%	951	1,122	84.8%
Child/Adolescent Consumer Survey Results	Number of Positive Responses	Responses	Percent	Number of Positive Responses	Responses	Percent	Number of Positive Responses	Responses	Percent
1. Percent Reporting Positively About **Access.**	100	128	78.1%	101	135	74.8%	190	230	82.6%
2. Percent Reporting Positively About **General Satisfaction** for Children.	86	127	67.7%	98	134	73.1%	180	231	77.9%
3. Percent Reporting Positively About **Outcomes** for Children.	73	125	58.4%	80	132	60.6%	143	228	62.7%
4. Percent of Family Members Reporting on **Participation in Treatment Planning** For Their Children.	85	127	66.9%	100	134	74.6%	188	228	82.5%
5. Percent of Family Members Reporting High **Cultural Sensitivity** of Staff. (Optional)	105	128	82.0%	115	134	85.8%	211	223	94.6%

Summary

There were a number of areas of improvement in 2010. For example, the survey response rates in 2010 were higher than in 2009 for both the adult and youth surveys. In addition, the confidence interval for the adult surveys was +/- 2.86% at the 95% confidence level in 2010, about the same as in 2009; however, the confidence interval for the youth surveys was +/-6.21% in 2010, compared to +/- 7.9% in 2009, a reflection of the higher response rate in 2010.

For the adult survey, responses to many of the questions on the survey were more positive in 2010 than in 2009, especially for the **Outcomes, Functioning** and **Social Connectedness.** However, the responses for the **Outcomes** and **Social Connectedness** domains continue to be the lowest of the seven domains.

There were some positive improvements in physical health conditions from 2009 to 2010. For example, fewer persons reported having had a heart attack, angina, high blood pressure, or diabetes in 2010 than in 2009. On the other hand, more people reported smoking cigarettes on a daily basis in 2010 than in 2009. Also, fewer persons reported being obese in 2010, but more persons reported being overweight.

In general, consumers reported that the services they received from community-based mental health and/or substance abuse programs had improved the quality of their lives. This was true especially for persons who received both mental health and substance abuse services. This is consistent with the results reported in Table 2, suggesting that when consumers are dealing with both mental health and substance abuse issues, receiving services that address both issues yields more positive results.

Appendix A

Adult Survey Questions[1] and MHSIP Scales

The 28 items on the MHSIP Adult Survey were grouped into five scales. The grouping of the items into the five scales is consistent with the groupings required for the national Center for Mental Health Services' Uniform Reporting System. Below are the five scales and the survey questions included in each scale.

Access:

1. The location of services was convenient (parking, public transportation, distance, etc.).
2. Staff were willing to see me as often as I felt it was necessary.
3. Staff returned my call in 24 hours.
4. Services were available at times that were good for me.
5. I was able to get all the services I thought I needed.
6. I was able to see a psychiatrist when I wanted to.

Quality and Appropriateness:

1. I felt free to complain.
2. I was given information about my rights.
3. Staff encouraged me to take responsibility for how I live my life.
4. Staff told me what side effects to watch out for.
5. Staff respected my wishes about who is and who is not to be given information about my treatment.
6. Staff here believe that I can grow, change and recover.
7. Staff were sensitive to my cultural background (race, religion, language, etc.).
8. Staff helped me obtain the information I needed so that I could take charge of managing my illness.
9. I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.)

Outcomes:

As a Direct Result of Services I Received:

1. I deal more effectively with daily problems.
2. I am better able to control my life.
3. I am better able to deal with crisis
4. I am getting along better with my family.
5. I do better in social situations.
6. I do better in school and/or work.
7. My housing situation has improved.
8. My symptoms are not bothering me as much.

Participation in Treatment Planning:

1. I felt comfortable asking questions about my treatment and medication.
2. I, not staff, decided my treatment goals.

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[1] Possible Responses: Strongly Agree, Agree, Neutral, Disagree, and Strongly Disagree

General Satisfaction:

1. I like the services that I received here.
2. If I had other choices, I would still get services from this agency.
3. I would recommend this agency to a friend or family member.

Two additional scales (and the questions included in each) were included in the 2010 survey.

Functioning:

As a Direct Result of Services I Received:

1. My symptoms are not bothering me as much.
2. I do things that are more meaningful to me.
3. I am better able to take care of my needs.
4. I am better able to handle things when they go wrong.
5. I am better able to do the things that I want to do.

Social Connectedness:

1. I am happy with the friendships I have.
2. I have people with whom I can do enjoyable things.
3. I feel I belong to my community.
4. In a crisis, I would have the support I need from family or friends.

Youth Survey Questions and MHSIP Scales

The Youth survey questions and MHSIP scales were:

Satisfaction:

1. Overall I am satisfied with the services my child received.
2. The people helping my child stuck with us no matter what.
3. I felt my child had someone to talk to when he/she was troubled.
4. The services my child and/or family received were right for us.
5. My family got the help we wanted for my child.
6. My family got as much help as we needed for my child.

Positive Outcome:

As a result of the services my child and/or family received:

1. My child is better at handling daily life.
2. My child gets along better with family members.
3. My child gets along better with friends and other people.
4. My child is doing better in school and/or work.
5. My child is better able to cope when things go wrong.
6. I am satisfied with our family life right now.

Cultural Sensitivity:

1. Staff treated me with respect
2. Staff respected my family's religious/spiritual beliefs.
3. Staff spoke with me in a way that I understood.

4. Staff were sensitive to my cultural/ethnic background.

Access:
1. The location of services was convenient for us.
2. Services were available at times that were convenient for us.

Family Involvement:
1. I helped to choose my child's services.
2. I helped to choose my child's treatment goals.
3. I participated in my child's treatment.

Improved Functioning:
As a result of the services my child and/or family received:
1. My child is better at handling daily life.
2. My child gets along better with family members.
3. My child gets along better with friends and other people.
4. My child is doing better in school and/or work.
5. My child is better able to cope when things go wrong.

Social Connectedness:
1. I know people who will listen and understand me when I need to talk.
2. I have people that I am comfortable talking with about my child's problems.
3. In a crisis, I have the support I need from family or friends.
4. I have people with whom I can do enjoyable things.

Calculation of Survey Scale Scores

The following methodology was used to calculate the survey scale scores:

1. Respondents with more than 1/3rd of the items in the scale either missing or marked "not applicable" were excluded.
2. For those respondents remaining, an average score for all items in the scale was calculated
3. For each scale, the number of average scores from Step 2 that were 2.49 or lower were counted (scores that, when rounded, represent "Agree" or "Strongly Agree" responses).
4. For each scale, the count from Step 3 was divided by the count of "remaining" records from Step 1 to obtain a percent of positive responses.

For example:

1. Of the 1,124 Adult surveys, 10 had more than 1/3rd of the items in the **Access** scale either missing or marked "not applicable". Those 10 surveys were excluded from the calculation of the **Access** scale, leaving 1,114 surveys to be included in the calculation.
2. Average scale scores were calculated for each of the 1,114 surveys
3. Of the 1,114 remaining surveys:

918 had average scores of 2.49 or lower (Agree/Strongly Agree)
155 had average scores between 2.50 and 3.49 (Neutral)
41 had average scores of 3.50 or higher (Disagree/Strongly Disagree)

4. The percent of "positive" responses for the **Access** scale was 918 (from Step 3) divided by 1,114 (from Step 1) = **82.4.**

Scale Reliability

Cronbach's alpha was used to measure internal consistency among the items in each scale. With the exception of the Adult **Participation in Treatment Planning** scale and the Youth **Access** scale, the results show consistency in measurement (reliability) among the items included in each scale.

Adult Scales (# of Items)	**Alphas**
Access (6)	.863
Quality and Appropriateness (9)	.917
Outcomes (8)	.921
Participation in Treatment Planning (2)	.684
General Satisfaction (3)	.893

Additional Adult Scales (# of Items)	**Alphas**
Improved Functioning (5)	.907
Social Connectedness (4)	.849

Youth Scales (# of Items)	Alphas
Satisfaction (6)	.931
Positive Outcome (6)	.927
Cultural Sensitivity (4)	.879
Access (2)	.611
Family Involvement (3)	.809

Additional Youth Scales (# of Items)	**Alphas**
Improved Functioning (5)	.936
Social Connectedness (4)	.824

Appendix B

Table 1
2010 Adult Consumer Survey
Summary of Results

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Other	% Agree/ Strongly Agree
1. I like the services that I received here.	475	514	65	30	36	4	88.3%
2. If I had other choices, I would still get services from this agency.	403	489	73	100	40	19	80.7%
3. I would recommend this agency to a friend or family member.	496	478	63	50	31	6	87.1%
4. The location of services was convenient (parking, public transportation, distance, etc.).	372	564	65	71	29	23	85.0%
5. Staff were willing to see me as often as I felt it was necessary.	449	523	57	43	26	26	88.5%
6. Staff returned my calls within 24 hours.	357	503	62	71	27	104	84.3%
7. Services were available at times that were good for me.	419	589	36	46	23	11	90.6%
8. I was able to get all the services I thought I needed.	410	527	59	81	40	7	83.9%
9. I was able to see a psychiatrist when I wanted to.	302	432	81	83	42	184	78.1%
10. Staff here believe that I can grow, change and recover.	466	491	74	26	22	45	88.7%
11. I felt comfortable asking questions about my treatment and medication.	453	524	51	34	17	45	90.5%
12. I felt free to complain.	366	569	71	67	18	33	85.7%
13. I was given information about my rights.	428	584	44	30	14	24	92.0%
14. Staff encouraged me to take responsibility for how I live my life.	435	539	64	32	18	36	89.5%
15. Staff told me what side effects to watch out for.	340	504	67	68	27	118	83.9%
16. Staff respected my wishes about who and who is not to be given information about my treatment.	490	520	47	19	19	29	92.2%
17. I, not staff, decided my treatment goals.	341	538	98	83	30	34	80.6%
18. Staff were sensitive to my cultural background (race, religion, language, etc.).	383	556	66	16	16	87	90.5%
19. Staff helped me obtain the information that I needed so that I could take charge of managing my illness.	388	580	57	45	24	30	88.5%
20. I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.).	298	512	95	82	20	17	80.4%
As a result of the services received:							
21. I deal more effectively with daily problems.	368	550	99	58	23	26	83.6%
22. I am better able to control my life.	355	567	96	61	18	27	84.0%
23. I am better able to deal with crisis.	311	580	123	61	18	31	81.5%
24. I am getting along better with my family.	310	530	141	58	17	68	79.5%
25. I do better in social situations.	268	532	157	88	24	55	74.8%
26. I do better in school and/or work.	217	425	131	60	21	270	75.2%
27. My housing situation has improved.	247	432	162	97	24	162	70.6%
28. My symptoms are not bothering me as much.	280	514	122	129	32	47	73.7%
29. I do things that are more meaningful to me.	313	577	116	74	10	34	81.7%
30. I am better able to take care of my needs.	316	606	104	54	14	30	84.3%
31. I am better able to handle things when they go wrong.	299	572	121	77	21	34	79.9%
32. I am better able to do the things that I want to do.	285	574	131	82	17	35	78.9%
33. I am happy with the friendships I have.	341	606	85	69	13	10	85.0%
34. I have people with whom I can do enjoyable things.	351	610	81	59	12	11	86.3%
35. I feel I belong in my community.	295	562	151	76	28	12	77.1%
36. In a crisis, I would have the support I need from family or friends.	431	556	78	42	11	6	88.3%
36a. The services you received at [Provider Name] has improved your quality of life.	340	548	111	48	33	44	82.2%

Table 2
2009 and 2010 Adult Consumer Surveys
Confidence Intervals (CI)

1 = Strongly Agree; 5 = Strongly Disagree	2009			2010		
	Mean	SD	95% CI	Mean	SD	95% CI
1. I like the services that I received here.	1.71	0.862	1.66-1.76	1.78	0.912	1.73-1.83
2. If I had other choices, I would still get services from this agency.	1.87	0.965	1.81-1.93	1.99	1.058	1.93-2.05
3. I would recommend this agency to a friend or family member.	1.73	0.891	1.68-1.78	1.79	0.940	1.73-1.85
4. The location of services was convenient.	1.84	0.918	1.78-1.90	1.93	0.942	1.87-1.99
5. Staff were willing to see me as often as I felt it was necessary.	1.76	0.869	1.71-1.81	1.79	0.888	1.74-1.84
6. Staff returned my calls within 24 hours.	1.90	0.996	1.84-1.96	1.93	0.961	1.87-1.99
7. Services were available at times that were good for me.	1.77	0.862	1.72-1.82	1.80	0.849	1.75-1.85
8. I was able to get all the services I thought I needed.	1.90	1.012	1.84-1.96	1.94	1.015	1.88-2.00
9. I was able to see a psychiatrist when I wanted to.	2.08	1.091	2.01-2.15	2.08	1.076	2.01-2.15
10. Staff here believe that I can grow, change and recover.	1.77	0.844	1.72-1.82	1.75	0.846	1.70-1.80
11. I felt comfortable asking questions about my treatment and medication.	1.75	0.890	1.70-1.80	1.74	0.817	1.69-1.79
12. I felt free to complain.	1.93	0.980	1.87-1.99	1.90	0.886	1.85-1.95
13. I was given information about my rights.	1.75	0.830	1.70-1.80	1.74	0.767	1.69-1.79
14. Staff encouraged me to take responsibility for how I live my life.	1.77	0.812	1.72-1.82	1.77	0.820	1.72-1.82
15. Staff told me what side effects to watch out for.	2.01	0.982	1.95-2.07	1.94	0.956	1.88-2.00
16. Staff respected my wishes about who and who is not to be given information about my treatment.	1.69	0.827	1.64-1.74	1.68	0.785	1.63-1.73
17. I, not staff, decided my treatment goals.	1.99	0.924	1.93-2.05	2.01	0.978	1.95-2.07
18. Staff were sensitive to my cultural background (race, religion, language, etc.).	1.76	0.801	1.71-1.81	1.77	0.763	1.72-1.82
19. Staff helped me obtain information that I needed so that I could take charge of managing my illness.	1.84	0.881	1.79-1.89	1.85	0.863	1.80-1.90
20. I was encouraged to use consumer-run programs (support groups, drop-in clinics, crisis phone line, etc.)	2.00	0.965	1.94-2.06	2.02	0.946	1.96-2.08
As a result of the services received:						
21. I deal more effectively with daily problems.	1.93	0.886	1.88-1.98	1.92	0.906	1.87-1.97
22. I am better able to control my life.	1.96	0.896	1.91-2.01	1.92	0.881	1.87-1.97
23. I am better able to deal with crisis.	2.03	0.931	1.97-2.09	1.99	0.877	1.94-2.04
24. I am getting along better with my family.	2.04	0.986	1.98-2.10	2.00	0.890	1.95-2.05
25. I do better in social situations.	2.22	1.027	2.16-2.28	2.13	0.956	2.07-2.19
26. I do better in school and/or work.	2.21	1.021	2.14-2.28	2.11	0.948	2.05-2.17
27. My housing situation has improved.	2.22	1.020	2.15-2.29	2.19	1.009	2.13-2.25
28. My symptoms are not bothering me as much.	2.28	1.087	2.21-2.35	2.18	1.043	2.12-2.24
29. I do things that are more meaningful to me.	2.06	0.919	2.00-2.12	1.98	0.865	1.93-2.03
30. I am better able to take care of my needs.	1.99	0.878	1.94-2.04	1.94	0.833	1.89-1.99
31. I am better able to handle things when they go wrong.	2.13	0.973	2.07-2.19	2.04	0.917	1.99-2.09
32. I am better able to do the things that I want to do.	2.13	0.958	2.07-2.19	2.06	0.906	2.01-2.11
33. I am happy with the friendships I have.*	2.05	0.947	1.99-2.11	1.93	0.855	1.88-1.98
34. I have people with whom I can do enjoyable things.	2.01	0.968	1.95-2.07	1.90	0.829	1.85-1.95
35. I feel I belong in my community.*	2.24	1.069	2.17-2.31	2.08	0.946	2.02-2.14
36. In a crisis, I would have the support I need from family or friends.*	1.91	0.991	1.85-1.97	1.79	0.806	1.74-1.84

* Consumers responded significantly more positively to this question in 2010 than in 2009.

Table 3
2010 Youth Consumer Survey
Summary of Results

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Other	% Agree/ Strongly Agree
1. Overall, I am satisfied with the services my child received.	88	104	18	15	3	4	84.2%
2. I helped to choose my child's services.	82	105	15	24	2	4	82.0%
3. I helped to choose my child's treatment goals.	76	113	13	19	4	7	84.0%
4. The people helping my child stuck with us no matter what.	100	94	19	11	4	4	85.1%
5. I felt my child had someone to talk to when he/she was troubled.	74	110	20	15	5	8	82.1%
6. I participated in my child's treatment.	92	113	11	10	1	5	90.3%
7. The services my child and/or family received were right for us.	76	109	21	19	6	1	80.1%
8. The location of services was convenient for us.	84	122	7	13	4	2	89.6%
9. Services were available at times that were convenient for us.	83	125	12	9	3	0	89.7%
10. My family got the help we wanted for my child.	73	105	19	23	11	1	77.1%
11. My family got as much help as we needed for my child.	62	102	24	27	14	3	71.6%
12. Staff treated me with respect.	104	116	5	5	1	1	95.2%
13. Staff respected my family's religious/spiritual beliefs.	92	115	11	2	0	12	94.1%
14. Staff spoke with me in a way that I understood.	92	128	8	1	1	2	95.7%
15. Staff were sensitive to my cultural/ethnic background.	80	127	12	2	0	11	93.7%
As a result of the services my child and/or family received:							
16. My child is better at handling daily life.	57	104	28	26	15	2	70.0%
17. My child gets along better with family members.	53	103	40	24	7	5	68.7%
18. My child gets along better with friends and other people.	47	113	42	17	6	7	71.1%
19. My child is doing better in school and/or work.	58	92	41	28	9	4	65.8%
20. My child is better able to cope when things go wrong.	43	101	40	34	10	4	63.2%
21. I am satisfied with our family life right now.	53	104	29	32	14	0	67.7%
22. My child is better able to do the things he/she wants to do.	45	116	38	27	5	1	69.7%
23. I know people who will listen and understand me when I need to talk.	48	142	18	15	2	7	84.4%
24. I have people that I am comfortable talking with about my child's problems.	66	137	12	9	3	5	89.4%
25. In a crisis, I have the support I need from family or friends.	71	144	10	4	2	1	93.1%
26. I have people with whom I can do enjoyable things.	72	145	9	4	1	1	93.9%

Attachment B

03/07/2011

Substance Abuse Advisory Committee Meeting
March 8, 2011

PRESENTATION
BY
TOBACCO FREE NEBRASKA

The Toll of Tobacco in Nebraska

- 2,200 adults die each year from their own smoking
- 16.7% (223,100) adults in NE smoke
- 36,000 kids now under 18 and alive in Nebraska will ultimately die prematurely from smoking
- 280 adult nonsmokers die each year from exposure to secondhand smoke

The Toll of Tobacco in Nebraska

- Annual health care costs in Nebraska directly caused by smoking reach $537 million
- The portion covered by the state Medicaid program is $134 million
- Residents' state and federal tax burden from smoking-caused government expenditures reaches $575 per household
- Smoking-caused productivity losses in Nebraska total $500 million

The Answer: Comprehensive Efforts

- Programming guided by best practices
- Efforts to protect people from secondhand smoke
- Support to help people quit
- Increases in the price of tobacco products

Goals of Tobacco Free NE

- Prevent initiation of tobacco use among youth and young adults
- Promote tobacco use cessation among adults and youth
- Eliminate exposure to secondhand smoke
- Identify and eliminate tobacco-related disparities

CDC's Best Practices

- Fund a comprehensive program
- Assist people in efforts to quit
- Implement research-based policies
- Protect people from secondhand smoke
- Increase tobacco prices

Nebraska Efforts

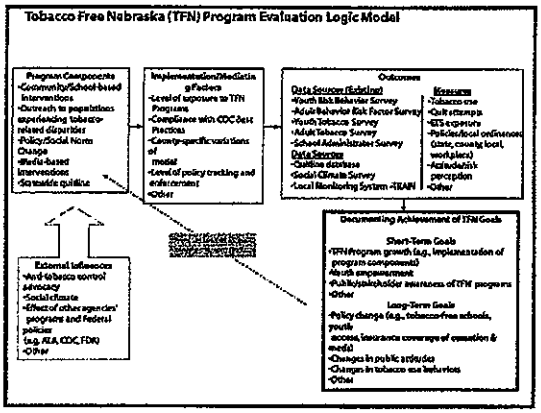
- In 2000, the Nebraska Legislature allocated $7 million a year for three years for a statewide comprehensive tobacco prevention and cessation program to:
  - Help people quit,
  - Eliminate exposure to secondhand smoke,
  - Keep youth from starting, and
  - Eliminate tobacco-related disparities.
  - Since 2004, the Nebraska Legislature has invested about $3 million per year to advance these goals.

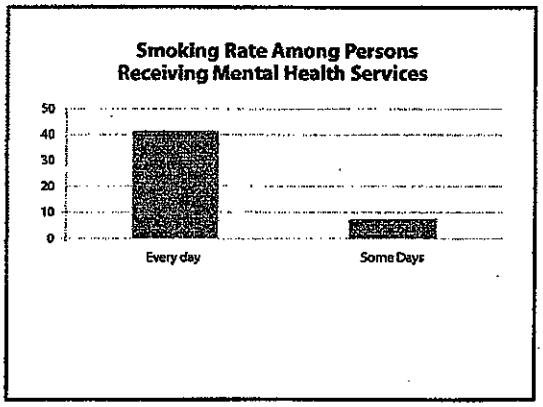
Program Components

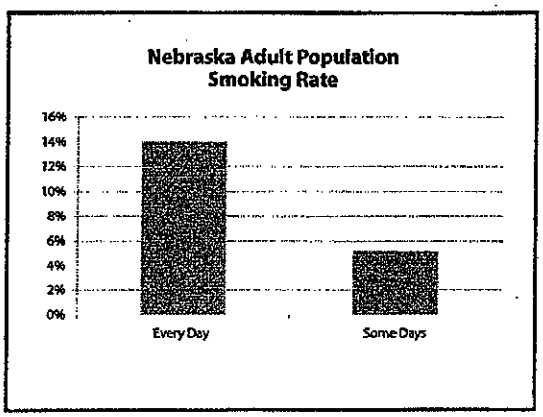
- The Nebraska Tobacco Quitline provides cessation counseling to tobacco users who want to quit or former users who want to stay quit.
- Community Grants – Nine community coalitions throughout the state provide a collaborative partnership through which tobacco prevention and secondhand smoke interventions are implemented.
- Media Campaign – Media efforts target preventing youth tobacco use, exposure to secondhand smoke and promoting the Nebraska Tobacco Quitline.

Program Components

- Nebraska's Youth Empowerment Movement is No Limits. A youth-led movement that engages youth to help prevent tobacco use.
- Measuring Progress (Surveillance and Evaluation). Tobacco Free NE measures and monitors the progress of the tobacco program goals and objectives via a variety of state specific data sources.
- Collaboration and outreach with populations (and agencies serving those populations) experiencing tobacco-related disparities.


Tobacco Free Nebraska (TFN) Program Evaluation Logic Model
Program Components
•Community/School-based Interventions
•Outreach to populations experiencing tobacco-related disparities
•Policy/Social Norm Change
•Media-based Interventions
•Statewide quitline
Implementation/Mediating Factors
•Level of exposure to TFN Programs
•Compliance with CDC best Practices
•County-specific variations of model
•Level of policy cracking and enforcement
•Other
Outcomes
Data Sources (Existing)
•Youth Risk Behavior Survey
•Adult Behavior Risk Factor Survey
•Youth Tobacco Survey
•Adult Tobacco Survey
•School Administrator Survey
Data Sources
•Quitline database
•Social Climate Survey
•Local Monitoring System -TRAIN
Measures
•Tobacco use
•Quit attempts
•ETS exposure
•Policies/local ordinances (state, county, local, workplace)
•Attitudes/risk perception
•Other
External Influences
•Anti-tobacco control advocacy
•Social climate
•Effect of other agencies' programs and Federal policies (e.g. FDA, CDC, FDA)
•Other
Documenting Achievement of TFN Goals
Short-Term Goals
•TFN Program growth (e.g., implementation of program components)
•Youth empowerment
•Public/stakeholder awareness of TFN programs
•Other
Long-Term Goals
•Policy change (e.g., tobacco-free schools, youth access, insurance coverage of cessation & media)
•Changes in public attitudes
•Changes in tobacco use behaviors
•Other


Smoking Rate Among Persons Receiving Mental Health Services
50
40
30
20
10
0
Every day
Some Days


Nebraska Adult Population Smoking Rate
16%
14%
12%
10%
8%
6%
4%
2%
0%
Every Day
Some Days

Why Quit?

- Nearly half of all cigarettes consumed in the U.S. are by individuals with a psychiatric disorder.
- People with serious Mental Illness, on average die 25 years younger than the general population – largely from conditions caused or worsened by smoking.

Reducing Tobacco Use

- Help consumers and staff quit using tobacco
- Support health, wellness and recovery!

Smoking Prevalence Among People with Mental Illness

Major Depression	50-60%
Anxiety disorder	45-60%
Bipolar Disorder	55-70%
Schizophrenia	65-85%

Source: Presentation at NASMHPD Medical Directors Council Technical Report meeting on Smoking Policy and Treatment in State-operated Psychiatric Hospitals, April 20-21, 2006, San Francisco, California. Dietz-Jones et al.

Barriers to Quitting

- Psychiatric medications are affected by smoking
- Quitting smoking affects psychiatric medications
- 2/3 of smokers want to quit but only 3% are able to quit
- Social interaction makes it hard to quit.
- May take more than one attempt to quit for good!

Stages of Change for Quitting Tobacco

- Pre-Contemplation: Not considering quitting and does not intend to quit.
- Contemplation: Not prepared to quit, but intends to quit in the next six months.
- Preparation: Actively considering quitting in the immediate future or within the next month.
- Action: Makes overt attempt to quit and is in the first six months of the process.
- Maintenance: Quit for longer than six months.

What TFN has to Offer

- Telephone quitline
- Medicaid program for medication and Quitline.
- Education information about quitting.
- Peer to peer program for quitting

Peer to Peer Training

- First training in October
- Looking towards second training in spring or summer.

JUDY MARTIN
TOBACCO FREE NEBRASKA
PROGRAM MANAGER
402-471-3489
judy.martin@nebraska.gov

SHIRLEY DEETHARDT
CESSATION PROGRAM COORDINATOR
402-471-0101
shirley.deethardt@nebraska.gov

Memorandum of Understanding for Supported Employment Services

The Division of Behavioral Health in the Nebraska Department of Health and Human Services (hereinafter referred to as Behavioral Health) and the Nebraska Department of Education, Vocational Rehabilitation (hereinafter referred to as Vocational Rehabilitation) have entered into a Memorandum of Understanding (hereinafter referred to as MOU) to increase employment opportunities for people with behavioral health (BH) problems.

I. PURPOSE

The parties agree that the purpose of the MOU is to coordinate and cooperate in the development and implementation of Supported Employment services for persons with behavioral health disorders. This includes but is not limited to:

A. Meeting periodically to review the approach used to providing Supported Employment (SE) Services across the Behavioral Health System including but not limited to an agreement to plan jointly where feasible, fiscal year commitment to funding for SE services, no reduction in money without notice to the other and an annual meeting to review the year just completed.
B. Exchanging information on funding levels, persons served, and related content in order to monitor and evaluate the implementation of the SE programs for persons with behavioral health disorders.

II. TERM OF MOU

The term of this MOU starts on July 1, 2008 and continues until one party provides notice to the other on the need to revise or end the agreement.

III. NOTICES

Any notice required to be given under the terms of this Contract shall be deemed duly sufficient if in writing, and if delivered or mailed to the parties listed below:

For Behavioral Health	For Vocational Rehabilitation:
Jim Harvey, Supported Employment Manager	Frank C. Lloyd, Assistant Commissioner/Director
Division of Behavioral Health Services	Vocational Rehabilitation
Phone: 402-471-7824	Phone: 402-471-3649
E-mail: jim.harvey@dhhs.ne.gov	E-mail: frank.lloyd@vr.ne.gov

IN WITNESS THEREOF, the parties have duly executed this MOU hereto and each party acknowledges receipt from the other party of a duly executed copy of this MOU with original signatures.

FOR THE NEBRASKA DEPARTMENT OF EDUCATION

Frank C. Lloyd — 8-6-08

Director of Vocational Rehabilitation — Date

FOR THE NEBRASKA DIVISION OF BEHAVIORAL HEALTH

[signature] — 8/1/08

Director of Division of Behavioral Health — Date
Nebraska Department of Health and Human Services

Attachment C

Mental Health Association of Nebraska

1645 'N' Street, Suite A
Lincoln, NE 68508

402-441-4371
402-441-4377 (FAX)
888-902-2822 (Toll Free)

www.mha-ne.org

Keya House
Annual Report: 2010

Total Guests (Unduplicated Count):	**83**
Total Guest Days:	**718**
Average Length of Stay:	**4.8 days**

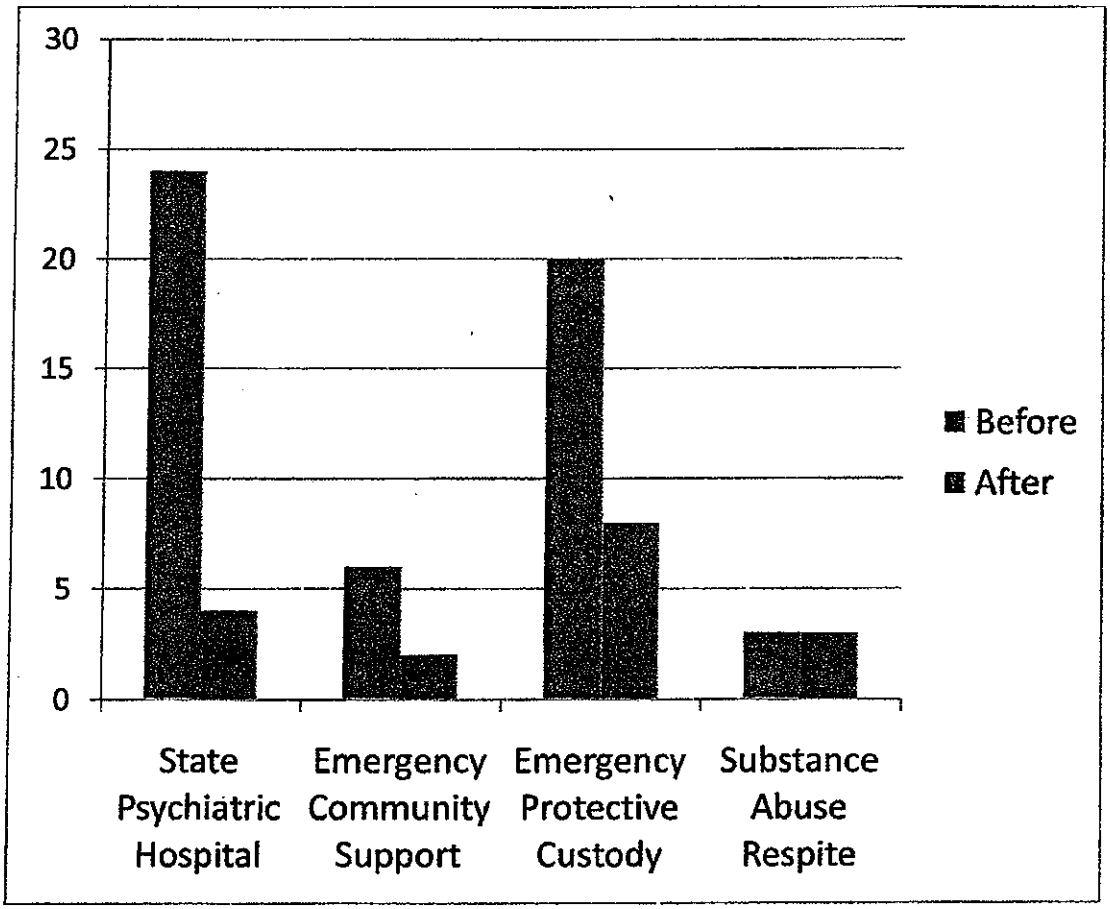
****

Unit Cost per Contract:	**$182 / Day**	**Total: $266,000**
Crisis Center:	**$600 / Day**	**718 day Total: $430,800**
BryanLGH:	**$1,200 / Day**	**718 day Total: $861,600**

CCMF

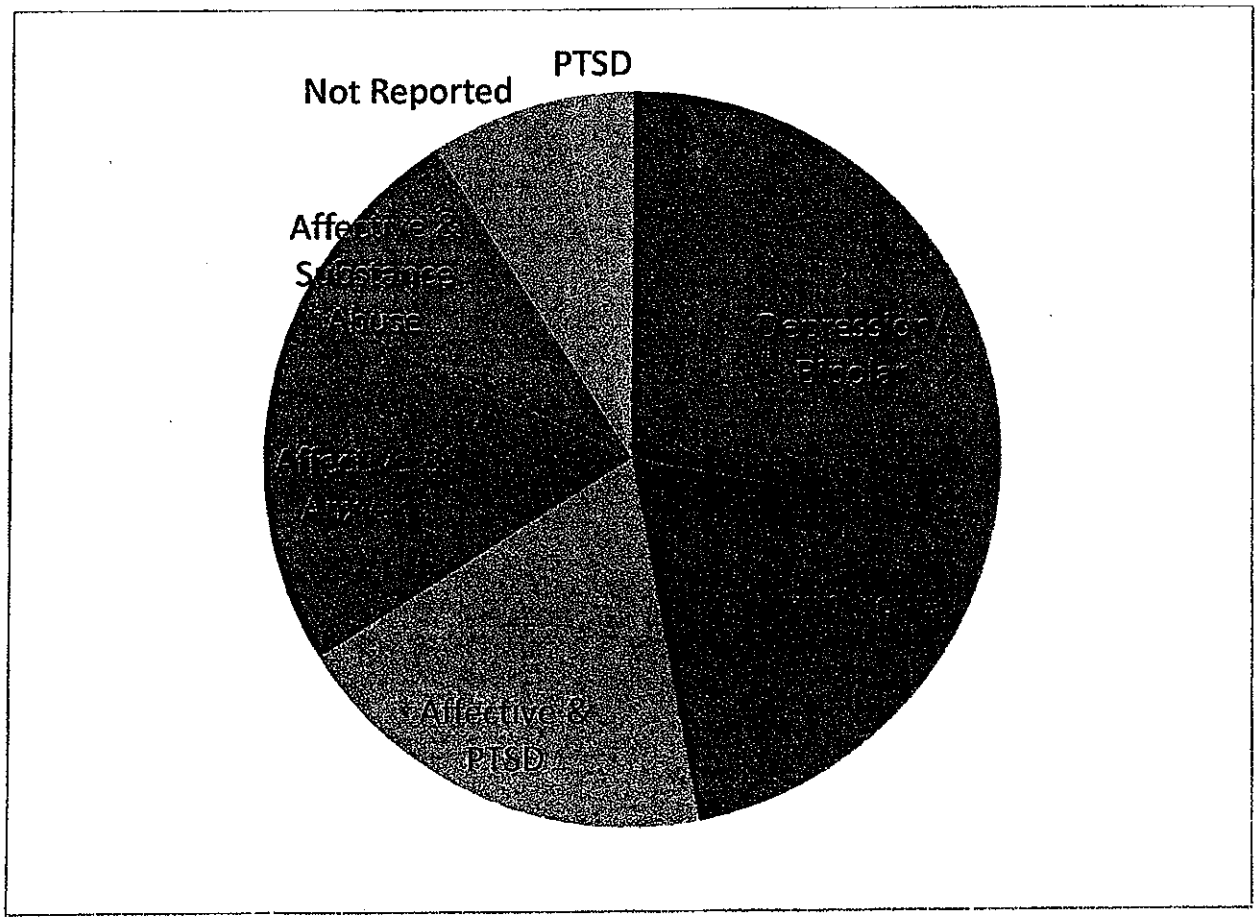
Nebraska Behavioral Health Region V provided the following data for Keya House guests' service utilization for the year prior and ten months following the opening of the Keya House.

*Overall, there was a **68% drop in utilization** of state and county-run emergency services.*



What are the demographic and clinical characteristics of Keya House guests?

- GENDER: 80% Female; 20% Male
- RACE: 90% White; 4% Black; 4% Hispanic/Latino; 2% Biracial
- EMPLOYMENT: 22% Employed; 3% Veteran
- HOUSING: 81% Independent Living



What do people like and dislike about their experiences at the Keya House?

Overall, guests indicate satisfaction with their stays at the Keya House.

86% *Strongly Agree* that coming to the Keya House helped them avoid going to the Emergency Room or Crisis Center.

77.8% *Strongly Agree* that guests get an orientation to the program and have a chance to discuss their reason for coming to the Keya House.

100% *Strongly Agree* that staff are available 24/7.

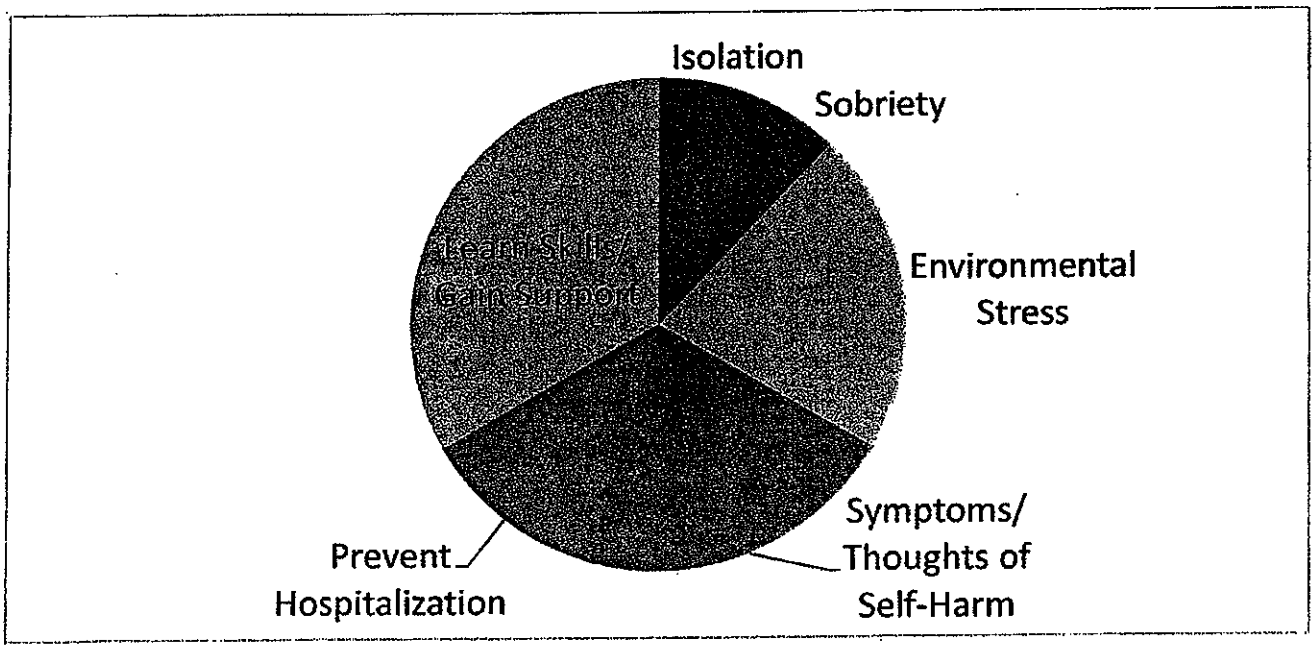
88.9% *Strongly Agree* that the quality of time spent with staff was good.

88.9% *Strongly Agree* that staff and guests are respected equally.

97.2% *Strongly Agree* that the house was neat and attractive, and that the facilities were clean and sanitary.

97.2% *Agree* or *Strongly Agree* that overall, they felt comfortable in the Keya House.

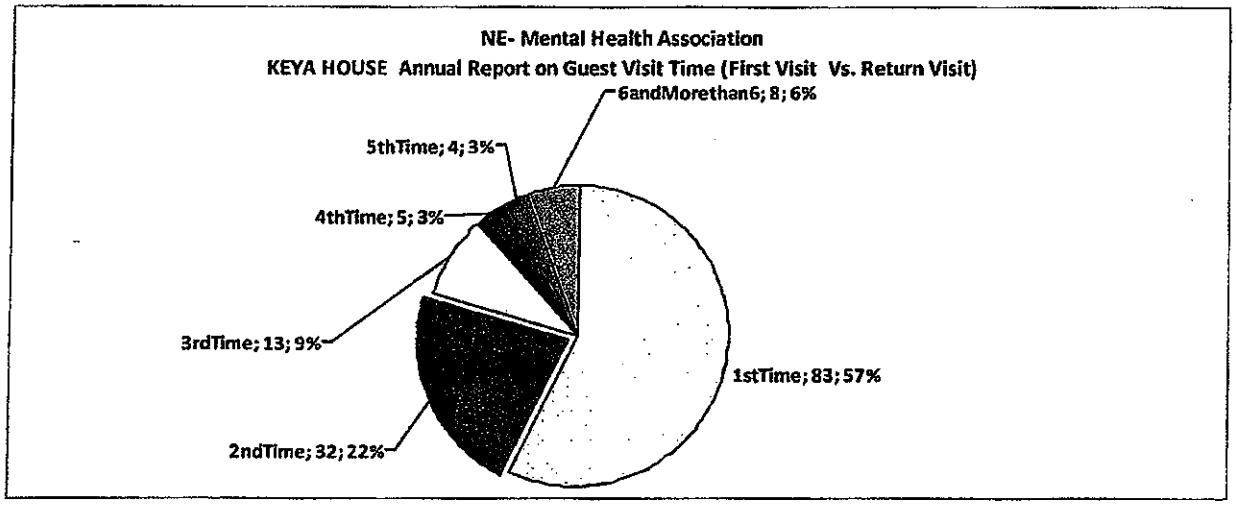
What circumstances stimulate people to use the Keya House?



Mental Health Association Of Nebraska - KEYA HOUSE PROGRAM Report

From: 12/10/2009 To: 2/2/2011

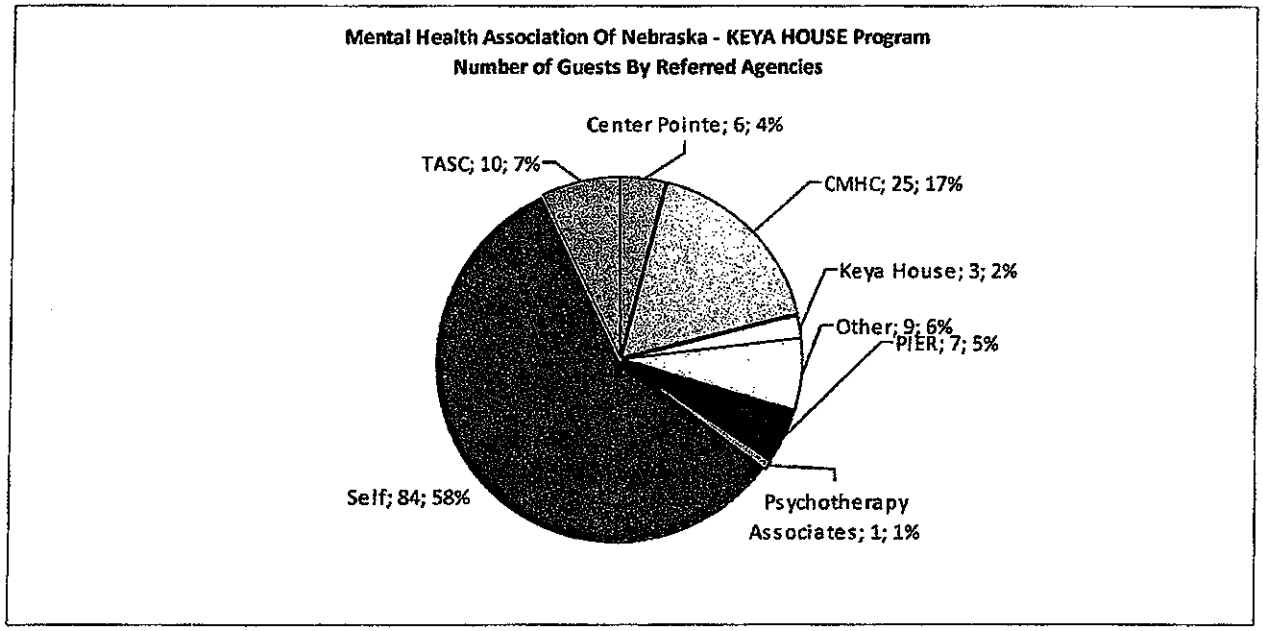
Month/Year	1st time Of Staying	2nd Time of Staying	3rd Time of Staying	4th Time of Staying	5th Time of Staying	6th and above
01-2010	18	2	0	0	0	0
01-2011	4	2	2	0	1	0
02-2010	2	3	1	0	0	0
03-2010	6	1	2	1	0	0
04-2010	5	2	1	0	0	0
05-2010	5	4	0	0	1	0
06-2010	4	2	0	0	0	0
07-2010	4	1	2	0	0	1
08-2010	5	4	1	1	1	1
09-2010	9	5	1	1	0	3
10-2010	6	1	2	0	0	2
11-2010	5	1	0	1	1	0
12-2009	4	1	0	0	0	0
12-2010	6	3	1	1	0	1
Total	**83**	**32**	**13**	**5**	**4**	**8**



NE Mental Health Association - KEYA HOUSE - Total Guests By Referred Agencies

From: 12/10/2009 To: 2/2/2011

Referred Agency Name or Self Refer	Total Guests
Center Pointe	6
CMHC	25
Keya House	3
Other	9
PIER	7
Psychotherapy Associates	1
Self	84
TASC	10
Total Guests of this period time:	**145**



Attachment D

Region 6 Behavioral Healthcare
Update for State Mental Health Advisory Committee
February 3, 2011

FAST FACTS:

- **Region 6 Counties:** Cass, Dodge, Douglas, Sarpy, and Washington
- **Geographic Area:** 2,048 square miles
- **2008 Population Estimate:** 734,500
- **Percent of State Population:** 41.2%
- **Number of Full-Time Staff:** 40
- **Projected FY 11 Revenue:** $26.6 million
- **Revenue Sources:** Federal and state funds through contracts with Nebraska Department of Health and Human Services, county match funds received through interlocal agreement
- **Mission:** To organize and provide an effective and efficient system of quality behavioral Health services for the people of Cass, Dodge, Douglas, Sarpy and Washington Counties.

WHAT WE DO:

Professional Partners:

Traditional:

- Assist children/youth experiencing behavioral or emotional concerns by identifying and coordinating community-based resources; create working partnerships between family and natural supports
- Age 0-21
- Includes School and Family Enrichment Program (SAFE) collaboration with Omaha Public Schools and Child Saving Institute
- 11 Professional Partners

Transitional (started June 2009):

- Unique, individualized support to youth/young adults with mental health needs to assist with transition to the adult service system (includes youth aging out of child welfare system)
- Age 16-25
- Focus on independent living skills
- 3 Professional Partners

Rapid Response (started January 2010):

- Short-term (90 days) services for severely emotionally disturbed youth to achieve goals of stability, improved functioning, and reduced need for involvement in juvenile legal system.
- Age 0-19
- Referred through County Attorneys
- 3 month program
- 4 Professional Partners

In FY 10, the Professional Partner Program served 323 youth, of which:

- 207 males (64%) and 116 females (36%)
- 55 Hispanics (17%) and 268 Non-Hispanics (83%)
- 239 Whites (74%), 57 Blacks (18%), 6 American Indians (2%), and 21 (6%) Multi-Racial
- Average length of stay was 6.2 months
- Statistically significant change (admission to discharge)
- 94% of discharged youth experienced no out-of-home placement

Network Management:

- Responsibilities regarding planning, development, and coordination of publicly-funded behavioral health services in statute
- Contract with 18 community-based organizations providing 35 levels of care; 12,243 persons served through 24,089 admissions in FY 10. Of the unique number of individuals served:
  - 75% had annual income of $9,999 or less
  - 56% of persons served accessed mental health care; 44% accessed substance abuse treatment
  - 55% were between 19 and 39 years of age; 23% were between 40 and 49 years of age
  - 74% were Caucasian; 17% African American; 3% American Indian; 6% All Others

FY 10 Highlights:

- Developed priorities for use of LB 603 (Safe Haven) funds: mobile crisis response and Rapid Response Professional Partners.
- Expanded mobile crisis response program capacity.
- Provided coordination of behavioral health response after recent high school shooting.
- Developed grant proposal to create intensive discharge planning project with 19-24 year olds coming out of jail.
- Developed network provider system goals and standardized outcome process measures by service. Partnered with University of Nebraska at Omaha to enhance expertise.
- Transitioned all behavioral health individuals out of Norfolk Regional Center.
- Continued grant for third year through the Nebraska Planning Council on Developmental Disabilities to promote collaboration between the behavioral health and developmental disabilities systems and to provide training to community providers.
- Continued leadership and participation roles in the Co-Occurring Task Force.
- Completed competitive bidding process to fund capital projects.
- Completed competitive bidding process to expand peer support specialist capacity.
- Provided service enhancement funds to substance abuse residential providers to meet needs of individuals with dual disorder.

- Funded new community support service for youth transitioning out of co-occurring residential treatment.
- Funded new family programming service to provide treatment, support, and education to family members of persons served in substance abuse residential treatment.
- Due to efforts of the Clinical Review Team (CRT), 89% of persons referred from local hospitals were served in the community and not admitted into a regional center. Since 2005, the CRT has worked with 1,315 individuals, both through diversion efforts as well as those transitioning back to the community from a regional center.
- Using CRT model, creating Homeless Review Team to (HRT) provide individualized housing, medical and behavioral health case planning for homeless individuals.
- Established Transitional Resources for Youth (TRY) Consultation Team.

FUTURE PLANNING

- Budget reduction implications
- Assessment, Outpatient and Medication Management Access
- Children/Youth and their Families
- Special Populations (e.g., Elder, Nursing Home, Criminal Justice, Sex Offenders)
- Crisis Prevention/Early Intervention
    - Education
    - Mobile Crisis Response
    - Crisis Intervention Training (CIT)
- Peer Services
- Role of/Reliance on Regional Center
- Training and Technical Assistance
    - New Rules and Regulations
    - Healthcare Reform
- Public/Private Partnerships
    - Implement Strategic Planning Initiative

Attachment E

State Advisory Committee for Mental Health Services (February 3, 2011)

"'Seeing' a person who is homeless is not enough—he/she needs a place to belong"
(testimony from a man who stated that he finally feels like he is home after 20 years of being in and out of homelessness; December 10, 2010 at 2010 PATH Grantee Meeting)

Projects for Assistance in Transition from Homelessness (PATH)

- The PATH program is administered by the Center for Mental Health Services, a component of the Substance Abuse and Mental Health Services Administration (SAMHSA), within the U.S. Department of Health and Human Services.
- PATH is a formula grant to the 50 states. *Nebraska currently receives $300,000 per year.*
- PATH services are for people with serious mental illness, including those with co-occurring substance use disorders, who are experiencing homelessness or at risk of becoming homeless. PATH services include community-based outreach, mental health, substance abuse, case management and other support services, as well as a limited set of housing services.
- Focus of Outreach = develop a relationship with an individual to assist him/her move toward readiness for change
- Focus of Case Management = access to housing and maintenance services

Messages from SAMHSA and the 2010 PATH Grantee Meeting

1. **PATH Priorities:**
   - PATH priority population is those who are literally homeless
   - PATH priority service is Outreach
   - Focus on ending homelessness, especially Veterans and families, in ten years

2. **Homeless Management Information System (HMIS)—Data Reporting:**
   - The HMIS in Nebraska is currently managed by the Nebraska Homeless Assistance Program within the DHHS-Division of Children and Family Services
   - PATH is moving toward a HMIS as soon as practicable. Most Nebraska providers are already collecting housing and homeless related data via ServicePoint.
   - Challenges as we move forward:
     - ✓ *Concerns about licensing fees for ServicePoint*
     - ✓ *Concerns that HMIS provides only aggregated data and no client-level data*
     - ✓ *Concerns that an individual can refuse to give any or all of their personal information—which will skew data and actual numbers of individuals being served*
   - PATH acknowledges the need for consistent Service Definitions and more quantifying of data; Federal Service Definitions must be reviewed/re-written to ensure consistency among providers and with other federal housing programs
   - PATH Annual Data Reporting—PATH is encouraging a move to actual data versus estimated data

3. **Where are we going?**
   - Are PATH providers involved in any homelessness Prevention activities?
   - Are PATH providers using Evidenced-Based Practices in PATH services?
   - Who is managing SOAR in your Region? How do we connect PATH to SOAR?
   - How well are PATH programs connected to Mental Health Services?—How many individuals are getting connected to Community Mental Health Services due to PATH?

4. **Final thoughts**
   - Housing is necessary for Recovery
   - Access to Housing allows access to Healthcare

For more information, please contact Nancy Heller, Nebraska Division of Behavioral Health, State PATH Coordinator, 402-471-7823 or nancy.heller@nebraska.gov

Attachment F

A CONSUMER CONTROLLED COUNCIL COMMITTED TO
ENSURING QUALITY REHABILITATION SERVICES

REPORT OF THE NEBRASKA

State Rehabilitation Council

2009-2010

SRC

State Rehabilitation Council
Nebraska Department of Education

November 5, 2010

To the Citizens of the State of Nebraska:

The State Rehabilitation Council (SRC) is pleased to present to you the 2009-2010 Annual Report.

During the past year, the SRC has been working with Vocational Rehabilitation to improve and expand services for individuals with disabilities. This close working relationship has allowed the SRC to provide input in numerous areas that affect all people with disabilities.

As this report indicates, the council has been involved in many areas of VR this year. Areas are as follows:

- Streamlining the survey process by reducing the number from five surveys to three. By doing this the SRC can obtain more detailed responses in a more efficient manner;
- A Consumer Input Committee was formed. The purpose of this Committee is to gather input on VR;
- Supporting National Disability Awareness Month. Employers with a history of hiring those with disabilities were recognized by the SRC in communities across the State;
- Showing support to the Legislature for their continued full funding of the Vocational Rehabilitation program despite the financial challenges the State of Nebraska is encountering;
- Recognizing those that have demonstrated success in Self Employment with The Entrepreneur of Distinction award. The awards were given on July 14 in Lincoln;
- Provided guidance regarding VR's policy on working with consumers that have substance addiction/abuse;
- Hosting a Senatorial Luncheon. Thirty Senators were present to hear from the SRC about the services VR provides;
- Supporting VR's effort to reach more consumers via social media outlets (facebook & YouTube);

This Council is committed to working in partnership with Nebraska Vocational Rehabilitation to identify how services can be improved to better meet the needs of its clients—those individuals with disabilities who are interested in achieving employment.

Sincerely,

Kipp Ransom

Kipp Ransom, Chairperson
Nebraska State Rehabilitation Council

301 Centennial Mall South • PO Box 94987 • Lincoln, NE 68509

Mitch is the President of Preferred Partners, LLC, an Omaha based recruiting company. He is a member of the SRC's Employer Services Committee.

Sharon is the parent of an adult son with disabilities and has been a member of Learning Disabilities of Nebraska for thirty years. She serves on the Client Services Committee.

Katie works at the Fairbury Youth Involvement Center in an after-school program. She is a member of the SRC's Transition Services Committee.

Teri is employed at the Lincoln Council on Alcoholism and Drugs. She serves on the Transition Services Committee.

In addition to farming, Alvin has an in-home business making greeting cards. He is a member of the Transition Services Committee.

SRC Committee Reports

Client Services Committee

Members: Sharon Bloechle, Tim Kolb, Leslie Novacek, Debra Osentowski, Kipp Ransom, Vicki Rasmussen, and Larry Niemeyer (Chair)

Don Crouch-VR Advisor

Members of the Consumer Services Committee focused this last year on gathering data to determine whether VR services, including the process of service delivery, resulted in consumers being successfully employed. A survey was the primary tool used in gathering data from VR consumers.

The Employment Warranty® Program survey data (started in October of 2009) continues to accurately reflect consumer opinion regarding the VR services they received while in the VR Program. The data will continue to be monitored.

Members of the Consumer Services Committee have continued to monitor data results from the Employment Discussion, Career Planning, and Job Search Strategy surveys. VR Office Directors have shared the data results with the Council throughout the past two years and concluded the results were not helpful in evaluating services and service delivery processes. A motion was made by the Council to discontinue the surveys and their decision is under consideration by Mark Schultz, Director of VR.

During the year, Kristen Lucas from UNL spoke with committee members about focus groups. As a result of this session, a Consumer Input Committee was created. The Consumer Input Committee includes several Consumer Service Committee members and seventeen consumers from across the state. Members respond to questions by email or phone. The initial data from the Consumer Input Committee is proving to be very helpful in improving VR Process.

Mark has requested that the Consumer Services Committee gather consumer feedback after using the *Discover the Job that Works for You* notebook during career planning. The committee will work on this in the upcoming year.

Larry has been employed with VR for over thirty-five years. He is the Chairperson of the Client Services Committee.

Client Services Committee Chairperson

Transition Services Committee

Members: Katie Durfee, Teri Effle, Alvin Fox, Seamus Kelly, Vicky Obrecht, Terry Wilson, and Angela Smith (Chair)

Jack Shepard-VR Advisor

The Transition Services Committee met five times in the past year. The Committee provided information to the members of the SRC on the Transition Summit held November 12, 2009 in Kearney and the Autism Conference held in Kearney on April 8-9, 2010.

The Committee received updates on the implementation of the transition blogs and the VR grant to the Autism Center of Nebraska for the development of supports and services for youth and other individuals with autism.

Project SEARCH was a frequent topic and Committee members were kept up-to-date on the current programs in Kearney and Grand Island. Also discussed was the expansion of the program in Norfolk, Lincoln, and other locations. Project SEARCH provides training and employment opportunities to high school students with disabilities.

The Committee was informed of the hiring of Mark Mason as the Youth Rehabilitation and Treatment Centers (YRTC) Liaison and his progress in development of a program to assist youth as they leave the YRTC and return to their community, enroll in school, or access VR and other services to assist with reintegration.

Based on data provided to the Committee, they recommended further research of ways to get and keep youth in the VR Transition Program.

The Committee would like to explore VR outreach to college students with disabilities who were in the VR Transition Program, but did not sign up with VR upon graduation from high school.

Angela works for Community Action Partnership of Mid-Nebraska. She is the Chairperson of the Transition Services Committee.

Angela Smith—Kearney

Transition Services Committee Chairperson

Susan (Sue) has a son who experiences a learning disability. Sue is on the Employer Services Committee. In addition, she is Vice Chairperson for the Council.

Seamus is employed at PTI Nebraska (Parent Training and Information for Families of Children with Disabilities). He is a member of the Transition Services Committee.

Tim was born with Werdnig-Hoffman Syndrome or spinal muscular atrophy. He serves on the SRC's Client Services Committee.

Leslie is the Director of Assistive Technology Partnership. She is a member of the Client Services Committee.

Vicki is the Special Education Coordinator for Lincoln Southeast High School with Lincoln Public Schools. She serves on the Transition Services Committee.

Debra joined the SRC as a parent of a son who has learning disabilities resulting from Epilepsy. She is a member of the Client Services Committee.

Kipp is the Lead Counselor on the Spinal Cord Injury Unit at Madonna Rehabilitation Hospital. He is the SRC Chairperson and serves on the Client Services Committee.

Vicki is the Director of the Nebraska Client Assistance Program (CAP). She is a member of the Client Services Committee.

Complications from a transplant left Terry unable to continue working. Terry contacted VR and successfully received services. He serves on the Transition Services Committee.

Pearl is the Executive Director of the Nebraska Commission for the Blind and Visually Impaired (NCVBI). She is a member of the Employer Services Committee.

SRC Committee Reports

Employer Services Committee

Members: Mitch Arnold, Sue Gieschen, Pearl Van Zandt, and Jason Kerkman (Chair)

Jim Coyle-VR Advisor

October 2009 was National Disability Employment Awareness Month. The SRC supported the revised strategic statewide plan implemented by VR to advocate for the employment of individuals with disabilities.

In February 2010, the SRC held its annual luncheon for State Senators. The luncheon educated the attendees about the services offered by VR and the positive impact VR is having on the citizens of Nebraska.

In July the SRC celebrated the Entrepreneurs of Distinction in the State of Nebraska. The award was given to individuals that have worked with VR and the Abilities Fund to become self-employed. The four criteria for the award were profitability, contribution to the community, innovation of ideas and hiring/expansion. Governor Dave Heineman presented the awards to the recipients at the July reception. Statewide media exposure was given to the event. The Entrepreneurs of Distinction award will continue to be awarded annually by the SRC.

This year the Employer Services Committee drafted the following mission statement: To increase the employment of people with disabilities by strengthening the relationship between VR, employers, and job seekers.

To support this mission the Committee developed and implemented an employer satisfaction survey to businesses across the state that have worked with VR. The Committee is also learning the role of temporary employment agencies in the business world and intends to develop guidelines for VR to strengthen their relationship with this group.

The Committee made the recommendation that Project SEARCH be the focus of the October 2010 National Disability Employment Awareness Month media outreach.

Jason is a Community Health Educator with Nebraska's Department of Health and Human Services. He is the Chairperson of the SRC's Employer Services Committee.

Employer Services Committee Chairperson

Annual Program Costs

	Cost of Program
Administration	**$3,322,848.00**

Client Services

	Cost of Program
Provided by VR Staff	$11,278,426.00
Purchased from Community Rehab Programs	$2,071,050.00
Purchased from Other Vendors	$5,809,207.00
Total	**$19,158,683.00**

Purchased for Clients

	Cost of Program
Assessment	$556,954.00
Higher Education	$1,844,083.00
Miscellaneous Training	$2,546,908.00
Maintenance	$186,727.00
Personal Assistance Services	$22,832.00
Transportation	$334,175.00
Rehabilitation Technology Services	$1,791,586.00
Small Business Enterprise	$318,990.00
All Other Services	$278,002.00
Total	**$7,880,257.00**

Message from the Director

As a new Director, I've appreciated the guidance and support of the State Rehabilitation Council during the last year.

SRC members have provided input on several fundamental changes for Nebraska VR. Their contribution is reflected in a new mission statement that provides for a dual customer focus of individuals with disabilities and businesses. Values have been adopted that will assist us as we make decisions about services and priorities. Guiding Principles were developed and will be integrated into our day to day work so that we can demonstrate our values as we provide services to individuals with disabilities and businesses.

I thank each of the SRC members for their commitment to helping us improve our services. It's been an exciting year and I look forward to more of the same in the year to come!

Mark Schultz, Director
Vocational Rehabilitation

Nebraskans Served by Vocational Rehabilitation

Consumers Served by Legislative District

District	Total	Percent
1	115	1.8
2	79	1.2
3	51	0.8
4	47	0.7
5	152	2.4
6	60	0.9
7	126	2.0
8	107	1.7
9	124	1.9
10	110	1.7
11	219	3.4
12	58	0.9
13	106	1.7
14	47	0.7
15	152	2.4
16	98	1.5
17	210	3.3
18	177	2.8
19	324	5.1
20	61	0.9
21	90	1.4
22	245	3.8
23	118	1.8
24	131	2.1
25	98	1.5
26	111	1.7
27	89	1.4
28	350	5.5
29	147	2.3
30	89	1.4
31	48	0.8
32	120	1.9
33	278	4.4
34	85	1.3
35	257	4.0
36	193	3.0
37	198	3.1
38	75	1.2
39	41	0.6
40	122	1.9
41	138	2.2
42	195	3.1
43	122	1.9
44	82	1.3
45	52	0.8
46	103	1.6
47	103	1.6
48	190	3.0
49	104	1.6
Total Served	**6397**	

NOTE: This does not include 4,832 served in the Transition Program or 6,114 served in the Employment Warranty® Program.

Funding

Every $1.00 appropriated for Vocational Rehabilitation by the Unicameral earns $3.69 Federal funding and yields $4.69 in services to Nebraskans with disabilities.

The Average Wage for Successfully Employed VR Clients

Average wage for 2010	$10.33
61% of clients are employed full-time	

2010 Nebraska Vocational Rehabilitation Employment Program

EMPLOYMENT PROGRAM	NUMBER OF PEOPLE
Applied for Services	5,069
Eligible for Services	4,513
Started Services	3,030
Received Services	6,397
Successfully Employed	1,677
Continuing in Services	3,642

2010 Program Categories

Employment Program	6,397
Transition Program	4,832
Employment Warranty® Program	6,114

2010 Occupation & Earnings for Competitively Employed Consumers

Occupations	Percent	Average Hourly Earnings
Services	34.3%	$8.71
Office Support	13.8%	$9.50
Professional	12.9%	$14.04
Sales	11.8%	$8.89
Transportation & Material Moving	7.5%	$10.11
Production	6.9%	$11.06
Installation, Maintenance, & Repairs	4.1%	$11.79
Management, Business, & Finance	3.5%	$15.22
Construction & Extraction	3.0%	$12.73
Farming, Fishing, & Forestry	2.0%	$11.04
Military	0.1%	$7.50

Partnerships with Employers & Vocational Rehabilitation

Some of the Companies Working with Nebraska Vocational Rehabilitation

- Affiliated Foods Midwest
- Alegent Health
- Allmand Brothers, Inc.
- Ameritas Group
- Amcon Distributing Co.
- Apogee Retail, LLC
- Associated Staffing Inc.
- Behlen Mfg. Co.
- Blue Ox
- Broyhill
- Bosselman Travel Centers
- Burlington Northern Santa Fe Railway
- Cabela's
- Chief Industries, Inc.
- CVS Pharmacy
- EGS Electrical Group
- Faith Regional Health Services
- First National Bank
- First Tier Bank
- Fremont Area Medical Center
- General Excavating
- Godfather's Pizza
- Good Samaritan Hospital
- Great Plains Regional Medical Center
- Hamilton Communication
- Heritage Homes of Nebraska, Inc.
- Home Depot
- Hughes Brothers, Inc.
- Husqvarna
- Hy-Vee
- InfoUSA
- Kawasaki
- Lincoln Journal Star
- Lindsay Manufacturing Co.
- Madonna Rehabilitation Hospital
- Methodist Hospital
- Nebraska Game & Parks Commission
- Nebraska Machine Products
- New Holland North America, Inc.
- Norfolk Iron & Metal Co.
- Omaha Tribe of Nebraska
- Pamida
- Pay Pal
- Reinke Manufacturing, Inc.
- Russell Speeder's Car Wash
- Safeway
- Saint Elizabeth Regional Health Center
- Saint Francis Medical Center
- Samuelson Equipment Co.
- Sehnert's Bakery & Bieroc Cafe
- Spherion
- Tabitha Health Care Services
- Target
- Toiln Products, Inc.
- TravelCenters of America
- University of Nebraska–Kearney
- University of Nebraska–Lincoln
- Vishay Dale
- Vulcraft Group
- Walgreens
- Wal-Mart Distribution Center
- Wal-Mart Stores
- Werner Enterprises, Inc.
- West Corporation
- Western Nebraska Community College
- Wimmer's Meat Products Inc.

2010 Successful Employment Businesses

- Artist (2)
- Barber Shop
- Butter Maker
- Custom Home Theatre
- Delivery Service
- Gas Station/Convenience Store Owner
- Gunsmith
- Lawn Service
- Massage Therapist
- Photographer
- Singer/Songwriter
- Taxidermist

Return on Investment for the Vocational Rehabilitation Program

On average, a successfully employed person returns $9.80 to the taxpayers for every $1 spent through Vocational Rehabilitation services.

Average cost of vocational rehabilitation services per person		$15,387.23
Average Annual Earnings after vocational rehabilitation services		$18,200.54
Estimated Annual Taxes on earnings:		
	Federal Income Tax	$1,412.32
	State Income Tax	$526.76
	State/Local Sales Tax	$303.46
	Social Security Tax	$2,784.79
	Average Total Taxes per Year	$5,027.33
Average Return to Taxpayers over 30 remaining years of employment		$150,819.95

Vocational Rehabilitation Client Success Stories

JACK MANN

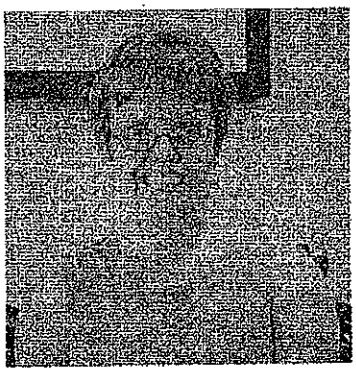
Growing up in a small town in western Nebraska, Jack Mann was used to working twelve hours a day, seven days a week in the hay mills.

But, as time went on, Jack found himself turning to alcohol and spent many years battling the addiction.

With the help of Nebraska Vocational Rehabilitation and the Abilities Fund, Jack has now turned his life around. Sober for several years, every day is an adventure for Jack as he owns and operates Brady Get-N-Go in Brady, Nebraska.

Jack's business includes a fuel station, tire shop, deli market, grocery store, convenience store and a liquor store all in one building. VR and the Abilities Fund helped him create a business plan for the store and provided financial assistance to get started.

"God picked me up out of the gutter of alcoholism and between Voc Rehab and the Abilities Fund, I got a new start," Mann said. "It's been quite the ride."



SUSAN KUIPERS

Susan Kuipers prefers to think of her short stature as "vertically challenged." This type of thinking is nothing new for her because she was born with a type of dwarfism called Achondroplasia.

After working at First National Bank for 13 years, Susan was laid off due to budget cuts. As she looked for a new job, she knew she would need some help from VR with worksite accommodations in order to be successful on the job.

Susan is now the front desk receptionist at an Omaha law firm. VR and Assistive Technology Partnership (ATP) have provided step stools, tables, and a custom-built keyboard tray among other things to help her be productive and comfortable.

"They (VR) have come up with more ideas than I would have thought of," Kuipers said. "They are super people that will bend over backwards to help you get back into the real world and working and being a productive citizen so that you feel good about yourself."

ANDY FRAIRE

In high school, classes were difficult for Andy Fraire because of a learning disability.

After working with VR, Andy, along with several other students, was referred to a new training program called Project SEARCH starting up in the Grand Island community.

SEARCH is a program to teach vocational skills to students with disabilities. Andy and the other selected students received on-the-job training at Saint Francis Medical Center in Grand Island.

"I really learned in Project SEARCH how to stay on task, show up to work on time, come into work when they need me and don't call in sick that much, and be respectful and do what the boss says," Andy said.

Andy successfully completed the Project SEARCH program and is now employed full-time at Saint Francis Medical Center.

BY-LAWS FOR THE
STATE ADVISORY COMMITTEE ON MENTAL HEALTH SERVICES
Proposed Amendments – February 3, 2011

Attachment G

Article I – Name of Organization

The name of the organization shall be the State Advisory Committee on Mental Health Services.

Article II – Purpose

Section 1
As provided by Nebraska Revised Statutes section 71-814 the purpose of the Committee is to ~~(1) serve as the state's mental health planning council as required by Public Law 102-321, (2) provide advice and assistance to the division relating to the provision of mental health services in the State of Nebraska, (3) promote the interests of consumers and their families, (4) provide reports as requested by the division, and (5) engage in such other activities as directed or authorized by the Division. Division means Behavioral Health Services.~~

(a) serve as the state's mental health planning council as required by Public Law 102-321, (b) conduct regular meetings, (c) provide advice and assistance to the division relating to the provision of mental health services in the State of Nebraska, including, but not limited to, the development, implementation, provision, and funding of organized peer support services, (d) promote the interests of consumers and their families, including, but not limited to, their inclusion and involvement in all aspects of services design, planning, implementation, provision, education, evaluation, and research, (e) provide reports as requested by the division, and (f) engage in such other activities as directed or authorized by the division.

The Division means the Division of Behavioral Health within the Nebraska Department of Health and Human Services.

Section 2
"Serve as the state's mental health planning council as required by Public Law 102-321 means meeting the requirements for the State Mental Health Planning Council under the Federal Community Mental Health Services Block Grant. Under Section 1914, the State will establish and maintain a State mental health planning council in accordance with the conditions described in this section. (b) The duties of the Council are:

(1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans [this refers to the Block Grant Application and Implementation Report], (2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems, and (3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

Section 3
MISSION STATEMENT
The Mission of Nebraska State Advisory Committee on Mental Health Services is to identify and advocate for an effective and efficient system of accessible, quality mental health services which enable each individual, on their journey of healing and transformation, to achieve their highest potential.

BY-LAWS FOR THE
STATE ADVISORY COMMITTEE ON MENTAL HEALTH SERVICES
Proposed Amendments – February 3, 2011

VISION STATEMENT
The Vision of Nebraska State Advisory Committee on Mental Health Services is to advise and assist the Division as it provides information for all Nebraskans, including consumers, families and the public to understand mental health problems, and to provide the knowledge necessary to access and utilize appropriate services in a timely, effective manner.

Article III – Membership

Section 1
Appointments: The committee shall consist of twenty-three members appointed by the Governor.

Length of Term: The length of term is as appointed by the Governor.

Section 3
Attendance: A member who has two consecutive unexcused absences shall be contacted by the Division regarding his/her intentions for future participation in the Committee. If the person indicates he/she is not able to participate, the Division shall request he/she formally resign from the Committee. Formal resignation shall be in writing and is to be submitted to the Director of the Division of Behavioral Health. The Division staff will maintain attendance sheet and submit to Chairperson periodically or per request.

Article IV - Voting

Section 1
Quorum: A quorum shall consist of one member more than half of the current members of the Committee Once established, a quorum shall be deemed to continue throughout the meeting. All Committee business shall be conducted by a simple majority vote of members present at a meeting in which a quorum is established.

Section 2
Conflicts of Interest: A conflict of interest is created through the existence of circumstances where the actions of a member may have an effect of direct financial benefit or detriment to the member, a member of his/her family, employer, business associate, or a business in which the member owns a substantial interest. As soon as the member is aware of a potential conflict of interest (or should reasonably be so aware), the member shall complete the Potential Conflict of Interest Statement Form C-2. The Form shall be submitted to the Nebraska Accountability and Disclosure Commission. The member shall follow all directions as prescribed and advised by the Nebraska Accountability and Disclosure Commission. If a dispute arises as to whether a conflict exists, the chairperson shall direct that the member's vote be disregarded on a given issue until such time as the member is in possession of a written opinion from the Nebraska Accountability and Disclosure Commission. Meeting minutes shall record the name of a member(s), who abstains from voting.

BY-LAWS FOR THE
STATE ADVISORY COMMITTEE ON MENTAL HEALTH SERVICES
Proposed Amendments – February 3, 2011

Article V – Officers

Section 1
Selection: Officers of the Committee shall be a Chairperson, Vice-Chairperson and Secretary.

Section 2

Duties: The duties of the Officers shall be:

Chairperson – Preside at all Committee and Executive meetings and:
(1) Attend annual technical assistance meeting on MH Block Grant
(2) Represent Nebraska at the MH Block Grant application review
(3) Write a letter representing the committee's point of view after reviewing the MH block grant application, to be attached and is due September 1.
(4) Write a letter after reviewing Mental Health block grant implementation report due December 1
(5) Perform any other duties designated by the Committee.
(6) Review attendance report and contact members as needed.

Vice-Chairperson - Shall act for the Chairperson in his/her absence. Shall perform other duties as designated by the Chairpersons or Committee

Secretary – Shall act for the Chairperson and Vice-Chairperson in their absence. Shall perform other duties as designated by the Chairpersons or Committee and is designated to review meeting minutes prior to distribution to committee members.

Section 3
At the fall meeting the committee will select officers for one year. The new officers' term are January 1 through December 31. In the event of a vacancy, the Committee will elect a member to serve the unexpired term of office.

Section 4
Executive Committee: The Executive Committee shall consist of the Chairperson, Vice-Chairperson and Secretary. A Chairperson may call the Executive Committee together with the approval of the Division, at his/her discretion.

Article VI - Meetings

Section 1
Frequency: Meetings of the Committee shall be held regularly.

Section 2
Conduct: Meetings shall be held in accordance with the requirements of the Nebraska Public Meetings Law, Neb. Rev. Stat. sections 84-1408 through 84-1414. Business should be conducted according to Roberts Rules of Order.

BY-LAWS FOR THE
STATE ADVISORY COMMITTEE ON MENTAL HEALTH SERVICES
Proposed Amendments – February 3, 2011

Section 3
Notice: The time, date and location of the next meeting should be determined prior to adjournment of the preceding meeting. Notification of the time, date and location of the next meeting shall be sent within two weeks to all members absent from the preceding meeting. Within thirty days, but not less than seven days prior to the next meeting, the Division shall mail ~~a written reminder~~ and meeting agenda to each Committee member at his/her last known official address.

Section 4
Duties of the Division: The Division shall provide an orientation to each new Committee member, produce meeting minutes, maintain records to include attendance record of the Committee, and provide support to the Committee.

Section 5
Expenses: Committee members shall be reimbursed for actual and necessary expenses in the performance of their duties as provided in Neb. Rev. Stat. sections 81-1174 to 81-1177.

add space

Article VII - Committees

With the written approval of the Division, the Chairperson may appoint or otherwise establish ad-hoc task forces comprised of Committee and non-committee members to accomplish a specific task which is relevant to the purpose of the Committee. Ad-hoc Committee is defined as including committee and non-committee members.

Article VIII – Amendments

There shall be a review of the Bylaws a minimum of every three years. A two-thirds majority vote of all Committee members will be required to amend the Bylaws. No Bylaws shall be considered for amendment unless notice of the same shall have been established as part of the meeting agenda, and a copy of the proposed changes has been ~~mailed~~ delivered to members within thirty days, but not less than seven days, prior to the meeting at which the vote will take place.

All alterations, amendments, or new by-laws adopted by the Committee are subject to the approval of the Director of the Division of Behavioral Health or the designated representative for the Director.

71-814. State Advisory Committee on Mental Health Services; created; members; duties.

(1) The State Advisory Committee on Mental Health Services is created. Members of the committee shall have a demonstrated interest and commitment and specialized knowledge, experience, or expertise relating to the provision of mental health services in the State of Nebraska. The committee shall consist of twenty-three members appointed by the Governor as follows: (a) One regional governing board member, (b) one regional administrator, (c) twelve consumers of behavioral health services or their family members, (d) two providers of behavioral health services, (e) two representatives from the State Department of Education, including one representative from the Division of Vocational Rehabilitation of the State Department of Education, (f) three representatives from the Department of Health and Human Services representing mental health, social services, and Medicaid, (g) one representative from the Nebraska Commission on Law Enforcement and Criminal Justice, and (h) one representative from the Housing Office of the Community and Rural Development Division of the Department of Economic Development.

(2) The committee shall be responsible to the division and shall (a) serve as the state's mental health planning council as required by Public Law 102-321, (b) conduct regular meetings, (c) provide advice and assistance to the Division relating to the provision of mental health services in the State of Nebraska, including, but not limited to, the development, implementation, provision, and funding of organized peer support services, (d) promote the interests of consumers and their families, including, but not limited to, their inclusion and involvement in all aspects of services design, planning, implementation, provision, education, evaluation, and research, (e) provide reports as requested by the Division, and (f) engage in such other activities as directed or authorized by the Division.

Source:

Laws 2004, LB 1083, § 14;
Laws 2006, LB 994, § 93;
Laws 2007, LB296, § 460.

FEDERAL COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

REQUIREMENTS FOR THE STATE MENTAL HEALTH PLANNING COUNCIL

Section 1914:

The State will establish and maintain a State Mental Health Planning Council in accordance with the conditions described in this section.

(b) The duties of the Council are:

(1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;

(2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and

(3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

(A) the principle State agencies with respect to:

(i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and

(ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;

(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;

(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and

(D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that:

(A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and

(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

BY-LAWS FOR THE
STATE ADVISORY COMMITTEE ON MENTAL HEALTH SERVICES
Proposed Amendments – changed per February 3, 2011 Meeting

Article I – Name of Organization

The name of the organization shall be the State Advisory Committee on Mental Health Services.

Article II – Purpose

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Proposed Amendments – changed per February 3, 2011 Meeting

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Quorum: A quorum shall consist of one member more than half of the current members of the Committee Once established, a quorum shall be deemed to continue throughout the meeting. All Committee business shall be conducted by a simple majority vote of members present at a meeting in which a quorum is established.

Section 2
Conflicts of Interest: A conflict of interest is created through the existence of circumstances where the actions of a member may have an effect of direct financial benefit or detriment to the member, a member of his/her family, employer, business associate, or a business in which the member owns a substantial interest. As soon as the member is aware of a potential conflict of interest (or should reasonably be so aware), the member shall complete the Potential Conflict of Interest Statement Form C-2. The Form shall be submitted to the Nebraska Accountability and Disclosure Commission. The member shall follow all directions as prescribed and advised by the Nebraska Accountability and Disclosure Commission. If a dispute arises as to whether a conflict exists, the chairperson shall direct that the member's vote be disregarded on a given issue until such time as the member is in possession of a written opinion from the Nebraska Accountability and Disclosure Commission. Meeting minutes shall record the name of a member(s), who abstains from voting.

Article V – Officers

Section 1
Selection: Officers of the Committee shall be a Chairperson, Vice-Chairperson and Secretary.

Section 2

BY-LAWS FOR THE
STATE ADVISORY COMMITTEE ON MENTAL HEALTH SERVICES
Proposed Amendments – changed per February 3, 2011 Meeting

Duties: The duties of the Officers shall be:

Chairperson – Preside at all Committee and Executive meetings and:

(1) Attend annual technical assistance meeting on MH Block Grant
(2) Represent Nebraska at the MH Block Grant application review
(3) Write a letter representing the committee's point of view after reviewing the MH block grant application, to be attached and is due September 1.
(4) Write a letter after reviewing Mental Health block grant implementation report due December 1
(5) Perform any other duties designated by the Committee.
(6) Review attendance report and contact members as needed.

Vice-Chairperson - Shall act for the Chairperson in his/her absence. Shall perform other duties as designated by the Chairpersons or Committee

Secretary – Shall act for the Chairperson and Vice-Chairperson in their absence. Shall perform other duties as designated by the Chairpersons or Committee and is designated to review meeting minutes prior to distribution to committee members.

Section 3
At the fall meeting the committee will select officers for one year. The new officers' term are January 1 through December 31. In the event of a vacancy, the Committee will elect a member to serve the unexpired term of office.

Section 4
Executive Committee: The Executive Committee shall consist of the Chairperson, Vice-Chairperson and Secretary. A Chairperson may call the Executive Committee together with the approval of the Division, at his/her discretion.

Article VI – Meetings

Section 1
Frequency: Meetings of the Committee shall be held regularly.

Section 2
Conduct: Meetings shall be held in accordance with the requirements of the Nebraska Public Meetings Law, Neb. Rev. Stat. sections 84-1408 through 84-1414. Business should be conducted according to Roberts Rules of Order.

Section 3
Notice: The time, date and location of the next meeting should be determined prior to adjournment of the preceding meeting. Notification of the time, date and location of the next meeting shall be sent within two weeks to all members absent from the preceding meeting. Within thirty days, but not less than seven days prior to the next meeting, the Division shall mail a written reminder and meeting agenda to each Committee member at his/her last known official address.

Section 4
Duties of the Division: The Division shall provide an orientation to each new Committee member, produce meeting minutes, maintain records to include attendance record of the Committee, and provide support to the Committee.

Section 5
Expenses: Committee members shall be reimbursed for actual and necessary expenses in the performance of their duties as provided in Neb. Rev. Stat.sections 81-1174 to 81-1177.

Article VII - Committees

With the written approval of the Division, the Chairperson may appoint or otherwise establish ad-hoc task forces comprised of Committee and non-Committee members to accomplish a specific task which is relevant to the purpose of the Committee. Ad-hoc Committee is defined as including Committee and non-committee members.

Article VIII – Amendments

There shall be a review of the Bylaws a minimum of every three years. A two-thirds majority vote of all Committee members will be required to amend the Bylaws. No Bylaws shall be considered for amendment unless notice of the same shall have been established as part of the meeting agenda, and a copy of the proposed changes has been delivered to members within thirty days, but not less than seven days, prior to the meeting at which the vote will take place.

All alterations, amendments, or new by-laws adopted by the Committee are subject to the approval of the Director of the Division of Behavioral Health or the designated representative for the Director.

BY-LAWS FOR THE
STATE ADVISORY COMMITTEE ON MENTAL HEALTH SERVICES
Proposed Amendments – changed per February 3, 2011 Meeting

71-814. State Advisory Committee on Mental Health Services; created; members; duties.

(1) The State Advisory Committee on Mental Health Services is created. Members of the committee shall have a demonstrated interest and commitment and specialized knowledge, experience, or expertise relating to the provision of mental health services in the State of Nebraska. The committee shall consist of twenty-three members appointed by the Governor as follows: (a) One regional governing board member, (b) one regional administrator, (c) twelve consumers of behavioral health services or their family members, (d) two providers of behavioral health services, (e) two representatives from the State Department of Education, including one representative from the Division of Vocational Rehabilitation of the State Department of Education, (f) three representatives from the Department of Health and Human Services representing mental health, social services, and Medicaid, (g) one representative from the Nebraska Commission on Law Enforcement and Criminal Justice, and (h) one representative from the Housing Office of the Community and Rural Development Division of the Department of Economic Development.

(2) The committee shall be responsible to the division and shall (a) serve as the state's mental health planning council as required by Public Law 102-321, (b) conduct regular meetings, (c) provide advice and assistance to the Division relating to the provision of mental health services in the State of Nebraska, including, but not limited to, the development, implementation, provision, and funding of organized peer support services, (d) promote the interests of consumers and their families, including, but not limited to, their inclusion and involvement in all aspects of services design, planning, implementation, provision, education, evaluation, and research, (e) provide reports as requested by the Division, and (f) engage in such other activities as directed or authorized by the Division.

Source:
Laws 2004, LB 1083, § 14;
Laws 2006, LB 994, § 93;
Laws 2007, LB296, § 460.

BY-LAWS FOR THE
STATE ADVISORY COMMITTEE ON MENTAL HEALTH SERVICES
Proposed Amendments – changed per February 3, 2011 Meeting

FEDERAL COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

REQUIREMENTS FOR THE STATE MENTAL HEALTH PLANNING COUNCIL

Section 1914:

The State will establish and maintain a State Mental Health Planning Council in accordance with the conditions described in this section.

(b) The duties of the Council are:

(1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;

(2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and

(3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

(A) the principle State agencies with respect to:

(i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and

(ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;

(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;

(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and

(D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that:

(A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and

(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.